Workshop on

REDUCTION OF DEMAND FOR

illicit drugs

in south-east asia

Penang, Malaysia. 14-20 May 1978

A COLOMBO PLAN PUBLICATION

THE COLOMBO PLAN

The Colombo Plan was launched in 1951 as a cooperative venture for the economic and social uplift of the people of South and South-East Asia. It had its origin in the intense desire and aspirations, after World War II, of the people of these countries for better standards of life, and the firm resolve of their friends and neighbours to assist them in achieving this objective by way of capital aid and technical cooperation.

The Plan was conceived at a meeting of Commonwealth Foreign Ministers in Colombo in January 1950. It has grown from its modest beginning as a group of seven Commonwealth nations into an international organization of 26 countries, surpassing its original geographical boundaries. Following the adoption of a new Constitution in December 1977, the name "Colombo Plan for Co-operative Economic Development in South and South-East Asia" was changed to "The Colombo Plan for Co-operative Economic and Social Development in Asia and the Pacific" in order to reflect more accurately the geographical composition of its expanded membership and the scope of its activities.

The founders of the Plan chose six years for its first life-span. The Consultative Committee has since extended the Plan's duration from time to time; its present life is until June 1982.

The 26 member countries of the Colombo Plan are: Afghanistan, Australia, Bangladesh, Bhutan, Britain, Burma, Canada, Fiji, India, Indonesia, Iran, Japan, Kampuchea, Republic of Korea, Laos, Malaysia, Maldives, Nepal, New Zealand, Pakistan, Papua New Guinea, Philippines, Singapore, Sri Lanka, Thailand and the United States.

The Plan revolves around four focal points:

(i) *The Consultative Committee, the principal review and deliberative body of the Colombo Plan, meets every year or two at Ministerial level in one of the member countries. It reviews the progress of member countries, discusses how available resources can best be used for development and exchanges views in a cooperative spirit on specific development problems;*

(ii) *The Council for Technical Co-operation consists of all members of the Colombo Plan. It meets at the official level several times a year in Colombo, Sri Lanka, where most of the countries have resident diplomatic missions. It assists in the development of the region by promoting technical cooperation and disseminates information on the concept and operation of the Plan in general, especially capital aid and technical assistance;*

(iii) *The Colombo Plan Bureau assists the Council in the discharge of its duties and responsibilities and participates in an advisory capacity in the Consultative Committee Meetings. The Bureau maintains a record of technical cooperation as well as capital aid given and received under the Colombo Plan, and issues publications and publicity material to highlight the aims and achievements of the Plan;*

Since 1973 the Bureau has been operating a Drug Advisory Programme to assist national and regional efforts to eliminate the causes and to ameliorate the effects of drug abuse. The Programme works in close cooperation with national and international agencies engaged in this field;

(iv) *The Colombo Plan Staff College for Technician Education, established in Singapore, was opened in March 1975. It helps member countries in developing their systems of technician education.*

Workshop on

PLANNING PROSPERITY TOGETHER

Reduction of Demand for Illicit Drugs in South-East Asia

Sponsored by the Government of Malaysia and the Colombo Plan Bureau

Organised by the Drug Advisory Programme
of the Colombo Plan Bureau
the United Nations Division of Narcotic Drugs
the World Health Organisation
the International Council on Alcohol and Addictions
the Universiti Sains Malaysia, and
the Ministry of Welfare Services, Malaysia

14 - 20 May 1978
Universiti Sains Malaysia
Minden
Penang, Malaysia

WORKSHOP REPORT

April 1979
The Colombo Plan Bureau
12, Melbourne Avenue, Colombo 4.
Sri Lanka

TABLE OF CONTENTS

PART SIX

Closing Session

PART SEVEN

List of Participants

INTRODUCTION

1. The member Governments of the COLOMBO PLAN BUREAU, recognising the increasing level of demand for illicit drugs - especially narcotic drugs in the South-East Asian region, and the problems associated with the assessment treatment and rehabilitation of those persons dependent on drugs suggested that the Drug Advisory Programme of the COLOMBO PLAN BUREAU investigate the feasibility of organising a regional workshop in this field.

2. The Government of Malaysia, through the University of Science Malaysia and Ministry of Welfare Services, kindly agreed to host this first regional workshop. The Drug Advisory Programme in collaboration with the United Nations Division of Narcotic Drugs, the World Health Organization, the International Council on Alcohol and Addictions, the National Drug Dependence Research Programme, University of Science Malaysia, and the Ministry of Welfare Services developed an appropriate programme for a six day workshop with the following objectives :

   a) To facilitate the assessment of drug abuse problems in participating countries;

   b) To promote the exchange of knowledge and experience in treatment and rehabilitation of drug dependent persons;

   c) To develop cooperation between professionals and administrators in drug demand reduction programmes in the countries concerned.

3. The regional workshop was held at the University of Science Malaysia from the 14th to 20th May 1978.

4. The Workshop was officially opened by the Minister of Welfare Services, Malaysia, Tang Berhormat Datin Paduka Aishah Ghani. The inaugural session was attended by Federal and State dignitaries, representatives of international and national agencies, other distinguished guests, participants and observers.

5. The workshop was structured so that the first three days were devoted to questions associated with the assessment of drug abuse problems and the second three days reviewed the various aspects of treatment and rehabilitation.

   Country reports, Consultant papers and Statements from varous international agencies were presented during the Plenary sessions. Each presentation was followed by discussion. More detailed discussions were held during the Group sessions. A total of 22 papers were presented. The technical committee which comprised the two chairmen,

Wednesday, 17th	9.00 - 10.00 a.m.	Reporting on Group Session A
	10.00 - 10.30 a.m.	COFFEE BREAK
	10.30 - 11.30 a.m.	Reporting on Group Session B
	11.30 - 12.30 noon	Summary of Discussions
	12.30 - 2.00 p.m.	LUNCH BREAK
	2.00 - 5.30 p.m.	**Current needs and future directions in assessment and recommendations** - Trends in programme development that should be strengthened in the region. - Additional areas of work that need to be developed - Specific need for national, regional and international co-operation
	8.00 p.m.	Dinner (Colombo Plan Bureau)

TREATMENT AND REHABILITATION

DAY/DATE	TIME	ACTIVITY	COUNTRY/AGENCY
Thursday, 18th	9.00 - 10.00 a.m.	Presentation	World Health Organization
	10.00 - 10.30 a.m.	COFFEE BREAK	
	10.30 - 11.30 a.m.	Presentation	Malaysia
	11.30 - 12.00 noon	Presentation	Malaysia
	12.30 - 2.00 p.m.	LUNCH BREAK	
	2.00 - 3.00 p.m.	Presentation	Help Centre
	3.00 - 4.00 p.m.	Presentation	Malaysia
	4.00 - 4.30 p.m.	COFFEE BREAK	
	4.30 - 5.30 p.m.	Presentation	Hong Kong
	5.30 - 6.30 p.m.	Group Session C	
Friday, 19th	9.00 - 10.00 a.m.	Presentation	Indonesia
	10.00 - 10.30 a.m.	COFFEE BREAK	
	10.30 - 11.30 a.m.	Presentaion	Philippines
	11.30 - 12.30 noon	Presentation	Singapore
	12.30 - 2.00 p.m.	LUNCH BREAK	
	2.00 - 3.00 p.m.	Presentation	Thailand
	3.00 - 4.00 p.m.	Presentation	Consultant
	4.00 - 4.30 p.m.	COFFEE BREAK	
	4.30 - 5.30 p.m.	Group Session D	
	8.00	Dinner (Malaysian Government)	

(Contd.)

Saturday, 20th	9.00 - 10.00 a.m.	Reporting on Group Session C
	10.00 - 10.30 a.m.	COFFEE BREAK
	10.30 - 11.30 a.m.	Reporting on Group Session D
	11.30 - 12.00 noon	Summary of Discussions
	12.30 - 2.00 p.m.	LUNCH BREAK
	2.00 - 4.30 p.m.	**Current needs and future directions in treatment and rehabilitation and recommendations**
		- Existing treatment programmes and evaluation - Innovative treatment approaches (including acupuncture, TC, etc.) - Possibilities for national, regional and international cooperation
	5.00 p.m.	CLOSING CEREMONY

PART ONE

Inaugural Session

INAUGURAL ADDRESS

By

H. E. Datin Paduka Haijah Aishah Haji Abdul Ghani
Minister of Welfare Services
Government of Malaysia

Mr. Chairman,

Ladies and gentlemen,

I feel greatly honoured to have been invited to declare open this auspicious Regional Workshop for South East Asian Countries on Drug Abuse Assessment - Treatment and Rehabilitation. On behalf of the Government of Malaysia, I would like to extend to all of you here, in whatever capacity you are, a cordial welcome to this memorable occasion.

Personally, I feel proud and happy that this Workshop is held in Malaysia because it has special significance to us, as we continue to be concerned with developing and improving our anti-drug programme. I feel sure that not only Malaysia, but all the countries represented here, will also immensely benefit from the mutual exchange of ideas. How valuable this Workshop is going to be, can obviously be judged from the high level participation of several eminent consultants in their particular fields from the various United Nations agencies including the United Nations Division of Narcotic Drugs, and the World Health Organisation, the Colombo Plan, the International Council on Alcohol and Addictions and from neighbouring and other countries.

I am also aware of the hard work and sacrifice that has been put in by certain organisations and people to make this Workshop a reality and therefore I take this opportunity of congratulating on my Government's behalf, as well as on my own, the Colombo Plan Bureau as represented by Attorney Pio Abarro for its financial contribution, and the Organising Committee without whose efforts we will not be able to be here.

Ladies and gentlemen, the theme of the Workshop - Drug Abuse Assessment - Treatment and Rehabilitation strikes me as most relevant and fitting for the countries represented here. It is because drug abuse, which has emerged as a new phenomenon, has engaged so much of our atttention, and has particularly presented the nation's leaders, planners, policy makers, and implementors with this perpetual question: What is the extent of the danger, and how do we get rid of it or control it?

Behind the drug abuse problem, I feel sure all national governments must have reasons to be concerned about the implications and far-reaching effects of drug abuse. No government wants to see its aspirations and efforts to raise the standard of living of its people thwarted. As the host country, I would like to acquaint you with the situation in Malaysia.

Drug abuse has come to be regarded as a serious social and national problem. It is especially serious and alarming considering that a large proportion of drug dependents are among the youth, and the number involved appears to be increasing as evidenced by the number of arrests of drug offenders, by the amount of hard drugs seized and finally by the number of drug dependents seeking treatment and rehabilitation. If drug abuse is not curtailed it will pose a serious threat to the well-being of the nation. We owe an obligation to protect our young people and to give them the best possible opportunity to grow up healthily and to play their role in nation building. We recognise their potential through their participation in the various sectors of industry, education, agriculture and national development. How important their contribution is can be appreciated by the fact that nearly 80% or nine million of the population of Malaysia consists of young people under 30 years of age.

My Government is determined to contain the problem, realising that if left unchecked, it will retard the nation's economic and social progress and educational development as well as endangering the security of the country. The law provides sufficient penalty to those who violate it through importation, sale, supply and distribution of illicit drugs. The court has power to inflict life sentence, whipping and even death penalty for those convicted under certain circumstances. But our main problem of rehabilitation still remains.

You are all aware that drug abuse is a multi-faceted problem encompassing law enforcement, prevention and control, education, treatment and rehabilitation. The effects of drug abuse are felt not only by individuals but also by the community. Many contributory factors come into play and personal problems, curiosity, weak family relationships, peer group influence, permissive morals, economic conditions, public ignorance and apathy are considered to be some of them. The geographical position of Malaysia also lends easy access of illicit drugs because of its close proximity to the golden triangle.

With this as the background, it has been necessary for Malaysia to approach the problem wholistically and not in fragmentated parts in order to understand the problem in its totality. This being the concept, the policy of the Government entails a multi-disciplinary approach utilising the combined resources of its machinery, the Ministry of Law, Police, Ministry of Welfare services, Ministry of Health and Central Narcotics Bureau which are directed towards the fulfilment of this policy. The support of voluntary organisations is also enlisted and in this regard, Pemadam (the National Association Against Drug Abuse) has played a key role. The importance of cooperation and co-ordination of these bodies attempts to ensure that the effects of the multi-disciplinary policy make their impact at the grass-root level.

Since the establishment of the Central Narcotics Bureau in 1974, extensive information and educational campaign has been waged to influence public opinion on the need for a concerted and relentless drive against drug abuse. The process of creating community awareness and to win community support in all aspects of the national programme is continuously

intensified. The spirit of encouraging public participation is now reflected in the legislation relating to their auxiliary role in drug rehabilitation within and outside the institution setting, as well as the establishment of private rehabilitation centres.

The introduction of legislation in 1975 represents my Government's realisation of the need for treatment and rehabilitation of drug dependents. Response has been overwhelming and justifiable as to make additional facilities and also modification of the programme structure necessary. Subsequent amendment of the legislation, the Dangerous Drugs Ordinance 1952, in 1977 has thus further streamlined the policy by removing the defects of the earlier legislation e.g. by introducing mandatory aftercare and probationary supervision by the Court for certain drug dependents and generally greater intervention of social workers in the integrated process.

I am indeed happy to announce that despite the fact that rehabilitation is a slow and tedious process involving time, energy and expense, my Government has given priority to expand the limited facilities available. My Ministry now operate three drug rehabilitation centres and under the five-year Third Malaysia Plan, the Ministry of Welfare Services has begun construction of a new Centre in Trengganu and proposes to build two additional rehabilitation centres, while the Ministry of Health will likewise increase its facilities for detection. In order to strengthen the operational machinery within the Ministry of Welfare Services, a separate rehabilitative unit will soon be set up, while at the same time, emphasis on staff training for all levels engaged in the work will continue to be given.

As I have stated earlier, so concerned is my Government with the drug abuse problem that it has established a Cabinet Committee, under the Chairmanship of the Hon'ble Deputy Prime Minister, solely entrusted with this responsiblility. Recently the structure is further strengthened by the establishment of an Executive Action Unit, which functions as a task force and coordinates and acts upon decisions reached by the Cabinet Committee.

We realise that our policy needs to be constantly reviewed in the light of experience. We need to ask ourselves this question: Is the money spent justifiable in terms of success obtained? Fortunately in this respect, we have the valuable contribution of the University of Science, Malaysia which has embarked in research into various facets of drug abuse. The Research Unit also co-ordinated all research activities which have policy implications and provides an advisory service to the Cabinet Committee. The findings of research studies will be valuable in influencing government policy. Accurate collection of statistics is vitally important and this University has wisely undertaken to set up a Central Data Bank, with information fed by all the Government referral agencies concerned, as to make it possible to know at any time the number of drug abusers registered. The on-going projects covering the analysis of the profile of the drug abuser, and the evaluation of the success or otherwise of rehabilitation programmes, will throw useful light in shaping future policies.

But, ladies and gentlemen, although sophisticated facilities can be devised, you will appreciate that there is not ready and easy solution to the problem. Experts present here will agree that it is one thing to enunciate theory but altogether another thing to implement it, even assuming that the theory holds water. This Workshop will thus provide you with an excellent opportunity of examining critically the validity of concepts and evaluate how far we have succeeded in reducing drug demand through rehabilitation of drug abusers.

If understanding of drug abuse can be traced to the dynamics of psycho-social needs of the individual, you will want to raise several questions. What policies and programmes, preventive and supportive, do you want for schools, families and the community so as to educate parents that a child deprived of his fundamental needs: affection, security, etc. is likely to abuse drugs as a psychological escapism? Do school programmes have preventive education to provide opportunities to motivate individuals to seek goals compatible with their potentials and capabilities ? We need also to ask ourselves if social workers, teachers and community workers, place enough stress on the preservation of the family as a viable unit in our society and family unit. These are some of the vital issues related to prevention of drug abuse as I feel confident that a child who is able to develop into a secure and confident individual is not likely to become a candidate of your interest.

I am fully aware that this is a colossal task when your goal is not just to change the abuser to become a useful citizen for a year or two but for the rest of his life, without reliance on drugs. your task becomes more complex considering the numerous constraints facing you, legal, administrative, financial and public apathy. Nevertheless, I am convinced that your presence here today signifies your willingness to accept this as a challenge.

On a lighter vein I do hope that all foreign participants, experts and consultants who have been kind enough to attend this Workshop would not only take part in serious discussions but would also take this opportunity to enjoy the sights of Penang which is our popular holiday resort and time permitting to visit other parts of the country. I can assure you of our most sincere welcome and I am sure that Organising Committee would be only too happy to extend to you any assistance in order to make your stay in our country a most enjoyable one.

Mr. Chairman, ladies and gentlemen, I now take the pleasure to officially declare this Workshop open.

WELCOME ADDRESS

By

Y. B. Sri Datuk Haji Hamdan Sheik Tahir
Vice Chancellor, University Sains, Malaysia

Y. B. Datin Paduka Hajjah Aishah Ghani, Menteri Kebajikan Am Malaysia. Y. B. Dato Mohamad bin Yeop Abdul Raof, Setiausaha Kerajaan Pulau Pinang dan Timbalan Pengerusi Majlis-Universiti Sains Malaysia. Y. M. Attorney Pio Abarro, Penasihat Dadah, Biro Rancangan Colombo. Tan Sri-Tan Sri, Datuk-Datuk dan seterusnya Tuan-tuan dan Puan-puan.

Dengan segala sukacitanya saya mengalu-alukan kedatangan Yang Berhormat Datin Paduka Hajjah Aishah Ghani yang telah bermurah hati sudi hadir bersama-sama kita pada hari ini untuk merasmikan Pembukaan Bengkel Mengenai Pengurangan Penggunaan Dadah Merbahaya di Asia Tenggara. Kami di Universiti Sains Malaysia berasa sungguh bangga kerana ini adalah kali kedua yang beliau berada di Universiti dalam masa satu bulan. Bagi pihak semua peserta-peserta, pemerhati, penasihat dan Jawatankuasa Pengelola, saya mengucapkan ribuan terimakasih kepada Yang Berhormat Datin Paduka.

Ladies and Gentlemen,

It is indeed my great pleasure and privilege to be able to welcome the Honourable Minister of Welfare Services Malaysia, Y. B. Datin Paduka Hajjah Aishah Ghani. She has very kindly consented to declare open this Workshop on the Reduction of Demand for Illicit Drugs in South-east Asia. On behalf of all of us present, I wish to express our very sincere gratitude and thanks to Y. B. Datin Paduka for sacrificing her valuable time to be with us today.

I would also like to take this opportunity to extend a very warm "selamat datang" to the participants and observers from the various countries, the representatives of the international and regional bodies, the consultants, the resource persons and all the distinguished guests. I know all of you are deeply concerned about the problems of the drug menace, which today affects numerous countries, and your presence encourages all of us who are associated in many such efforts directed to control and reduce drug abuse.

As the Vice-Chancellor of the University, I consider it an honour and privilege to host and organise on behalf of the Government of Malaysia this Workshop on the Reduction of Demand for Illicit Drugs in South-east Asia. This University has been very fortunate in having been given the task of serving as the venue of several workshops and conferences over the last few months. We have had a Unesco Workshop on Mass Communications;

a meeting of Registrars of the Commonwealth Universities in the South-east Asia and Pacific Area; a Regional Meeting on Education and the Problems Related to the Use of Drugs, and more recently a Colloquium on Oral History. However, this particular meeting is indeed an important one, since the theme of the meeting has direct relevance to our research efforts in the field of drug abuse control.

Many of you may be aware that this University has—as a key area of research—a major project on drug dependence, and accordingly the Government has decided to declare the University as the Centre for the National Research Programme on Drug Dependence. As recently as two months, the National Cabinet Committee on Drug Abuse Control under the chairmanship of the Honourable the Deputy Prime Minister, Dato Seri Dr. Mahathir Mohamed, was briefed on the various research findings, and about a fortnight ago the Hon'ble Minister of Education, Dato Sri Musa Hitam reviewed the current data and the research findings relating to drug use among the youths in the country.

Policy-makers and programme-planners need precise information on the nature, the extent and other factors before being able to formulate policy decisions on any social problem. Precisely why so many individuals in so many cultures are compelled to take drugs is a question that, for the present at least, defies any simple universal response. One approach to determine systematically the types of responses is by research, or more correctly POLICY-ORIENTED RESEARCH. This means that before the assessment of a problem can be undertaken, it is necessary for available data, indices and other factors to be collated scientifically in order to give a coherent perspective.

Research therefore should be viewed as an investigation, or a series of investigation, into specific issues. However research-in the sense in which I use it—should not be regarded as sacro-sanct; rather, it should be regarded as an integral component of a larger effort directed towards a common goal. In Malaysia, this goal is the reduction of demand for illicit drugs and their allied problems.

In the context of this workshop, it should be seen as an investigation of the characteristics and the dynamics of drug abuse, and the effectiveness of the social controls employed. It would, therefore, be an oversimplification to assume that good research can be conducted without rigorous attention to the rules and the logic of research or without the use of sophisticated techniques to ensure the reliability of the data and the validity of the findings. The research activity only becomes valid when it can serve the interests of both the researcher as well as the individuals to whom the findings of the research are presented i.e. the policy formulators.

In order to carry out such a task, a multi-disciplinary research group is needed. The important role of the computer and the many advances in computer technology must be recognised. I am of the view that to achieve the optimal allocation of resources, the development of sound management systems as well as the need to resolve complex issues, all will

require the extended development of computer technology. We, in this University, are very fortunate in having available for our research efforts the willing assistance and co-operation of good computer unit under the able leadership of Dr. Lim Huat Seng and his colleagues.

I understand that most, if not all of you, are experts in the field of reduction of demand for Illicit drugs. I do not consider myself an expert, but since I have been given the responsibility of overseeing the national research programme, I wish to raise a few issues. I am sure you all appreciate that it is not possible to talk of the reduction of demand for illicit drugs without giving due regard to the demand for different drugs; the inter-relationship between these demands; the formulation of the goals for reduction in specific terms, and the existence of the supply situation. Further, you must also spell out the underlying goal of demand reduction, is it the reduction of demand for those drugs, which in certain circumstances appear to be associated with the individual, social or societal problems.

The reduction of demand for illicit drugs should be seen as one response to the more fundamental goal of trying to curtail or better manage the problems which appear to be associated with drug use. Therefore, reduction of demand should be examined in specific situations in regard to specific drugs. Further it is important to note that the overall aim should be the limitation of the more injurious ramifications of drug use.

In the first part of the workshop, you will be examining the methods and the techniques that can be used in assessing the demand for drugs. You will be confronted with different survey methods—the anonymous self answering type, interview techniques, etc. as well as the development of national computer data monitoring systems. I strongly urge you to examine the many research issues carefully, remembering that your research will not be judged so much for its elegance, rather by its relevance to the fundamental and practical issues confronting policy-makers in your respective countries.

In the second part, you will be examining the types and the problems associated with treatment and rehabilitation of the drug dependent person. I hope you will evaluate the different modalities with an open mind, since there is no single approach that has been found proven to be effective in this area. Low success in this aspect is a common occurrence, and you must examine the many facets of each programme, and try if possible, to evolve one that is practical, and above all applicable to your own respective situations.

The National Research Project on Drug Dependence based at this University has already attempted to examine many of the issues you will be discussing. Some of their findings have been documented, and our research personnel in the School of Pharmaceutical Sciences, particularly Dr. V. Navaratnam and his colleagues, will be more than pleased to share their experience with interested persons during or after this meeting.

We are already working in close collaboration with the major ministries in this country, the United Nations—both the Commission and Division of Narcotic Drugs as well as the World Health Organisation.

In this regard, we have been able to make available technical resources and expertise to the United Nations Fund for Drug Abuse Control. I am also given to understand that the WHO has decided to use this University as an international data centre in relation to their Research and Reporting Project on the Epidemiology of Drug Dependence. We at this University, therefore, remain prepared to collaborate with any international agency or groups of interested researchers in the neighbouring countries.

I know that the task ahead for all the participants is an arduous one, but I am equally confident that you will face the numerous issues with confidence, skill and success.

Thank you.

REMARKS

By

Attorney Pio A. Abarro
Drug Adviser, Colombo Plan Bureau

Your Excellency Datu Paduka Haija Aisha Ghandi, Minister of Welfare Services, Tan Sri Datuk Hadji Hamdan Sheik Tahir, Vice-Chancellor, University Sains Malaysia, Encik Adnan bin Haji Abdullah, Director General of Welfare Services, Participants and Friends:

It gives me great pleasure to have the opportunity to meet you all and express on behalf of the Colombo Plan Bureau and the other co-organising agencies (World Health Organisation, United Nations Division of Narcotic Drugs, International Council on Alcohol and Addictions) our words of welcome to this opening ceremony of the regional Workshop on Reduction of Demand for Illicit Drugs in South East Asia. On behalf of the Colombo Plan Council for Technical Co-operation in Asia and the Pacific and on my own I wish to express our profound thanks and gratitude to the Government of Malaysia for hosting this regional Workshop.

I wish to express my regret for the inability of the Director of the Colombo Plan to be with us during this workshop. But she has conveyed her sincere good wishes for a successful exercise.

I wish to convey our deep appreciation to the Honourable Minister of Welfare Services for her presence with us to inaugurate this workshop inspite of her numerous duties of State. I would also like to thank the honourable Vice Chancellor of the University Sains Malaysia for his whole hearted cooperation and his acceptance of the Chairmanship of the Organising Committee and the commitment of the whole university and the staff towards this endeavour. Our thanks are also due to the Director-General of Welfare Services, the Director of the Central Narcotics Bureau and other staff whose unstinting support and cooperation has helped to make this exercise a reality.

I would also like, through the consultants present here to thank member countries of the Colombo Plan for their support and for making available to us the services of their experts. These countries are the United States of America, Hongkong (U.K.), Indonesia, the Philippines, Singapore, Thailand, Sri Lanka and of course Malaysia.

This Workshop is a sequel to the first national workshop on Prevention and Control of Drug Abuse in Malaysia which the Colombo Plan Bureau likewise co-sponsored with the Government of Malaysia about three years ago at the Genting Highlands. As I stand before you today I have a feeling of nostalgia and memories of that first Workshop coming to me especially so when I look at many familiar faces here who were participants in that first significant event.

I share the pride of many here from your country who were architects of the recommendations that had emerged from that workshop many of which have been adopted and fully implemented by your Government during the past three years. Many of those architects are now the policy makers of drug abuse control policies and some are heading the Malaysian Government's Federal Drug Abuse Prevention and Control offices.

The theme and objective of this workshop carry more significance in the light of the Government's concerted efforts in establishing its treatment/rehabilitation infra-structure and facilities.

I would not attempt to suggest any guidelines for your deliberations but rather would like to appeal to the participants and observers for cooperation and understanding of each others views or proposals in offering solutions to the ever elusive problems of drug abuse. In the light of our experiences it is beginning to be felt that cooperation both within the country and among countries is the answer to our problems. This experience is a good example of the cooperative undertaking. Several regional set-ups like the ASEAN and lately the Commonwealth Organisation are now involved in the prevention and control of drug abuse.

In closing allow me to convey to you my spontaneous feeling of gratification over the arrangements and facilities, magnificent and well considered hospitality beyond comparison. I am happy—no problems.

Saya dengan segala sukacitamya menguchapkan selamat besidang dan terima kasih.

MESSAGE

from

Dr. George Ling

United Nations Division of Narcotics Drugs
Geneva

Ladies and gentlemen, esteemed colleagues and dear friends,

It was an honour and a pleasure for me to have been invited to participate in the opening ceremonies of this important seminar, and it is with even greater regret that I find myself unable to do so since I had previously made commitments to attend another meeting at this same period.

As you are aware, this seminar which has been sponsored by the Colombo Plan Bureau, the Government of Malaysia, the World Health Organization, the International Council on Alcohol and Addictions and the Division of Narcotic Drugs will include among its desiderata three major objectives. These are:

a) to facilitate the assessment of drug abuse problems in participating countries;

b) to promote the exchange of knowledge and experience in treatment and rehabilitation of drug-dependent persons;

c) to develop cooperation between professionals and administrators in drug demand reduction programmes in the countries concerned.

Drug use in the cultural and social context of Asia, and of this region in particular has historical roots that can be traced to by-gone centuries; even then there was an appreciation of the dangers associated with the abuse of socially used drugs. Indeed, much of the early drug legislation in the world could well be traced to Asia; and in this region for example in the 14th century (1387) and the 18th century (1756) early edicts concerning restrictions in the Kingdom of Thailand and the States General of Batavia respectively dealt with penalties (forfeiture of land, physical punishment and fines) for the abuse of opium and cannabis derivatives. In addition, the teachings of the Koran, the five precepts of the Lord Buddha, the wisdom of the sages in Hinduism and of all leaders of the many faiths that form the religious fabric of this region have made it clear that the abuse of drugs is a social evil.

The most startling aspect of this social evil in this region has been the increasing use of heroin and related substances by young people and this concern is enhanced when one considers that the population in this dynamic and rapidly expanding economy are young in age and the abuse of drugs can have a damaging effect on their personal health and development as well as their societal contributions. The youth represent a very valuable asset of any country and it is mandatory that every effort be made to assist them to achieve productive national goals.

Your deliberations on this occasion are therefore of timely interest. They are also of vital importance to the concerted international effort to control drug misuse and abuse among vulnerable groups, as well as to reduce to the greatest extent possible the hazards associated with this disturbingly increasing phenomenon-hazards which are reflected in behavioural, social, pathophysiological, political, juridical and economic problems. A better understanding of drug misuse and abuse among such populations should therefore assist us in our endeavour to provide effective and realistic management programmes for the individual and for the community in both developed and developing countries.

In this connextion, collaborating investigators from diverse parts of the world, and in particular from this region have carried out pilot studies in order to arrive at a firmer basis for an understanding and assessment of drug abuse issues. It is therefore cogent that primary attention be paid to needs, desiderata and socio-economic conditions of developing countries and that mechanisms, processes and instruments of assistance for the control of drug abuse are structured to provide realistic and appropriate approaches. *In concert with this view, the Division of Narcotic Drugs at the request of the Commission on Narcotic Drugs has continued to place more emphasis on efforts to reduce the demand for drugs*, with the effective collaboration of the World Health Organization, the United Nations Educational, Scientific and Cultural Organization, the International Labour Office, the International Narcotics Control Board, the United Nations Division of Social Affairs and the International Council on Alcohol and Addictions. In this connextion, reliability, reproducibility and comparability of data are essential. They are essential firstly to deal with the nature and effectiveness of current policies, secondly to evaluate practices and programmes on the prevention of drug abuse, thirdly to structure effective and realistic treatment and rehabilitation activities and finally to be able to predict the possible impact which new and promising approaches may have on future drug abuse problems and their management. As an example, and in a related area of interest, these characteristics of data collection and their most careful evaluation can be of great help in monitoring the value of orally effective narcotic antagonists such as naltrexone. Naltrexone shows interesting promise in the management of drug dependent persons who seek total abstinence from the chronic use of opioid agonists, as well as in those who are at risk of becoming dependent. Indeed, if sound clinical data continue to demonstrate clearly the effectiveness of naltrexone intervention in the management of drug addiction, it would lend additional support to the heuristic studies of the role of centrally active peptides or endorphins on brain function, and addictive behaviour and would as well provide opportunities to develop more effective and realistic approaches to the treatment and rehabilitation of drug-dependent persons.

In addition, the real value and effectiveness of such approaches can only be evaluated by carefully and critically collected epidemiological data and in this as in other related activities, the Division recognizes and appreciates the efforts of the International Council on Alcohol and Addictions and the Colombo Plan Bureau. These efforts, I am confident, will be

reinforced by the active participation of consultants and experts whose demonstrated competence and expertise augur well for a stimulating and productive conference. Dr. M. Kilibarda, Chief, Drug Demand and Information Unit, will be able to provide you with information on the work of the Division of Narcotic Drugs.

I wish you every success in your deliberations and shall look forward to learning the conclusions and recommendations of this seminar. May I also in closing take this opportunity to express my sincere gratitude to the Vice Chancellor, Yang Berbahagia Tan Sri Datuk Haji Hamdan Sheikh Tahir, for his kindness in hosting this meeting at the University Sains Malaysia and for that hospitality for which this University community is so well known.

PART TWO

Recommendations

3.1. Monitoring System

There is a need for individual countries to establish continuing monitoring of drug abuse. Since patterns of use and drugs of abuse are often subject to rapid changes, current data are essential. In general, trend indicators collected in a uniform manner, on a continuing basis, and appropriate interpretation of the data are desirable for monitoring purposes.

3.2. Assessing Policy Changes

Close monitoring of the nature, extent, and consequences of drug use should be conducted to assess the impact of policy changes. It should be stressed that such monitoring should be alert to counterproductive as well as beneficial effects of policy changes. Since the control of one drug often leads to a switch to other drugs, or different modes of administration, it is essential that decision makers are provided with indicators of the net consequences of policy changes as early as possible. Where feasible, it may be desirable to test a new policy in only one or two locales prior to nationwide implementation.

4.1. Case registers and the issue of confidentiality

Case registers of drug users can provide useful information not available through monitoring indicators. However, they also have the potential for violations of individual confidentiality. No uniform policy is suggested on this issue; however, it is urged that appropriate precautions be taken to protect the individual in this respect.

RECOMMENDATIONS ON TREATMENT AND REHABILITATION PROGRAMMES

1. TREATMENT AND REHABILITATION PROGRAMMES

1.1. It is recognised that no existing method of treatment and rehabilitation has been satisfactorily proven to be so effective as to be recommended for standard use. It should be regarded as "experimental". Systematic data recording and evaluation component should be an essential part of the effort.

1.2. Each country should elect some form of multi-modality programme, i.e. in patient and out-patient clinics, maintenance therapy, therapeutic communities, acupuncture, etc. It is likely that each national effort will be unique. Regular meetings of the countries involved should occur on at least a yearly basis so that experiences may be exchanged.

1.3. Treatment and rehabilitation efforts should be regarded as subject to constant change. The Drug Abuse Policy Agency in each country should monitor constantly and be prepared to change demand reduction programmes to meet changing needs.

1.4. Rehabilitation should be extended in time with urine monitoring where appropriate, as an integral component of this effort. Rehabilitation and after care should be carried out for at least a two-year period.

2. TRAINING

2.1. Training on national and/or regional level of all concerned; medical and para-medical personal, social workers, personnel of the criminal justice system, correction and probation officers, ex-addicts and researchers should be carried out on a continuous basis.

2.2. Every effort should be made to keep the public informed of the availability of facilities and the development of programmes in the field of treatment and rehabilitation, in order to promote better understanding and increased co-operative participation on the part of society.

PART THREE

Assessment Techniques — Workshop Papers

ACTIVITIES OF W.H.O. IN THE ASSESSMENT OF DRUG DEPENDENCE

By

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Geneva

The need for improved methods for assessment of drug abuse and related problems was felt in WHO in the early 1970's when the World Health Assembly requested the Organisation to provide "for the international collection and exchange of data on the prevalence and incidence of drug dependence and on the human and environmental factors associated."[1] This was followed in 1973 with the publication of a WHO Expert Committee Technical Report on the Epidemiology of Drug Dependence[2] and in 1975 with the establishment of the UNFDAC supported inter-regional Research and Reporting Project on the Epidemiology of Drug Dependence. The WHO Regional Office for the Western Pacific in Manila has reflected its interest in improved epidemiological assessment in the recent publication of its report on Early Intervention Programmes in Drug Abuse.[3] Later this year the Regional Office is sponsoring a technical meeting on the Application of Laboratory Methods in the Surveillance/Epidemiology of Drug Dependence.

In this paper I would like to give a brief overview of current WHO assessment activities with special reference to the Research and Reporting Project on the Epidemiology of Drug Dependence. I would also like to raise for your consideration several issues that we may wish to address during the course of our discussions.

General Approach of the Research and Reporting Project

The central objective of this project is the development of basic methodologies to meet the priority data collecting needs of countries with serious problems of drug dependence. The initial step was to develop and pilot test instruments and methods for data collection on drug using groups such as patients in treatment and on "high risk" groups such as students and other youth populations. As instruments and methods are tested and finalised they will be published and made available for routine data gathering and for specific research studies. If the use of these instruments and methods become widespread, there should be a general improvement in the comparability and scientific quality of data being generated in this field.

The framework for implementing this project involves annual meetings with collaborating investigators and consultants in order to remain responsive to rapidly changing patterns of drug use and to review improved data collection and intervention methods. The annual meetings provide a framework for reviewing progress, priorities and future plans. A very

limited data management capacity has been established at the WHO Headquarters in Geneva to carry out developmental work. Future data processing activities in collaborative studies, however, will increasingly be carried out in collaborating institutions.[4] This is in keeping with current WHO policy to shift resources and technical activity, wherever possible, to the country level.

The selection of collaborating institutions has given priority to countries where UN/WHO treatment projects are being implemented, for example Burma and Thailand in this region of the world. The involvement of key technical personnel from these countries permits the identification of collaborative projects that meet the data collecting needs encountered by national experts in the process of implementing country programmes. It also provides an additional mechanism of technical support for these important country programmes.

Review of Completed and Current Work

The data collecting methodologies were finalised in 1977 and are now being prepared for publication. The first involved the testing of a common case reporting form for drug users.[5] It contained core demographic and drug use items previously agreed by collaborating investigators to meet the minimum essential data needs of planners of prevention and treatment programmes. The testing of these forms on 300 cases from each of six countries has generated for the first time comparable cross-national data on samples of drug users with different cultural backgrounds and patterns of drug use. Of more fundamental importance than the data generated was the adoption of a common set of items for measuring drug use pattern, that is the drug, duration, frequency and route of use. While not essential for independent investigations, one of the crucial issues that must be resolved in establishing international reporting systems for any disorder, is agreement on criteria for defining a case of the particular condition being measured. Otherwise there is no assurance that investigators in different parts of the world are reporting the same phenomena. Once this agreement is reached, then a variety of operational instruments can be generated and applied in different approaches and for different populations.

The decision to define cases in terms of drug use pattern information has the advantage that these data can be collected from most individuals either on self-completed questionnaires or in interviews by non-specialized personnel. The availability of a "disorder-producing agent" or drug, permits epidemiological collaboration in this field to depart in a fundamental way from international studies of functional psychiatric disorders, such as schizophrenia, in which a major emphasis has been placed upon collection of data on psychiatric symptoms, mental status and at times upon formal psychiatric diagnosis of each case by highly trained professionals.

A second completed study involved the testing of a self-administered student survey questionnaire which contained comparable data items to those just mentioned. The results of instrument testing in nine countries revealed high test-retest reliability of the drug use pattern questions. It

is planned to give the finalised instruments and methods wide-spread distribution as their use in future studies should contribute significantly to the comparability and reliability of drug use data on students and other youth groups. An important conclusion of this study is that while relatively inexpensive self-administered student questionnaire surveys are likely to reach most young people in industrialized countries, the majority of adolescents in developing countries are often not in school. Furthermore, the most serious forms of youthful drug dependence often occur among school drop-outs or urban youth from the lower-socio-economic classes who do not have the opportunity to attend educational institutions. For these reasons, a study is being implemented in 1978 to develop methods for surveying non-student youth, especially in developing countries.

During the coming year studies are being implemented to develop other needed methodologies. For example a collaborative study is developing the methodology for pre-intervention and post-intervention surveys of drug users in target communities selected for treatment and other intervention programmes. This study builds upon developmental work carried out by collaborating investigators in rural villages in Thailand,[6] and the general approach will now be tested in both urban and rural settings and in other countries. If it is successful, it will provide an operational framework for measuring the impact of demand reduction programmes on the number of active users in defined communities.

A closely related project will address the special technical issues involved in the assessment and management of traditional opium users in rural areas. A meeting will be sponsored in 1979 to bring together key planners and technical experts who are implementing epidemiological and intervention programmes in rural opium using communities. It is hoped that investigators can share their experience in this frontier area of programme development and for which there is almost no scientific literature to guide our future efforts.

One collaborating institution has offered to develop a comprehensive international review of case registers and national case reporting systems in drug abuse. The report will review exisiting experience and also provide practical guidelines for planners considering the various options for national data reporting systems.

The Research and Reporting Project did not select as an initial priority the development of a methodology for general population surveys. The reasons include their high cost and difficulty to resolve technical matter. We refer here to the tendency of such surveys to miss users in settings where drug users are punished or stigmatized, and are not motivated to identify themselves. However, WHO will now be collaborating in a Latin American country with national experts, UNFDAC and the UN Division of Narcotic Drugs to implement a national household survey of drug abuse. This is seen as an initial step toward the development of a practical methodology for conducting general population surveys in other countries.

The most recent study to be initiated by the Research and Reporting Project results from the coming into force of the Convention on Psychotropic Substances, as this has placed new responsibilities on WHO and on Governments who are parties to the treaty. One of these responsibilities is to schedule the level of control for individual psychotropic substances taking into account an assessment of the social and public health problems associated with their use. To assist WHO and governments to meet these responsibilities, standardised instruments and scales will be developed for assessment of these public health and social problems. It is hoped that the tested instruments will permit the collection of reliable and comparable information in different populations and cultural settings.

Early Findings and Trends

During the initial stage in the development of the Research and Reporting Project, instruments have been tested on relatively small and unrepresentative samples in participating countries. Nevertheless, the data generated have been sufficient to show that it is possible to collect comparable and reliable cross-national epidemiological data on drug users.

In addition, we observed that the data generated by collaborating institutions in South East Asia and Western Pacific countries are consistent with other reports suggesting a rapid increase in the use of heroin by urban youth. They report that they used drugs initially for social reasons and for satisfying curiosity. While they tend not to be so involved in theft and other forms of criminality, they appear to be in many other respects similar to young people involved in heroin epidemics in European and North American cities. In contrast, the data being generated on rural opium users suggest that many take the drug initially as self-medication for health problems. Because many are older adults suffering from chronic illness, a high proportion will require continuing medical management after they are withdrawn from opium dependence. While these trends in the data from initial studies must be viewed with caution, they do suggest that the larger studies projected for future collaboration are likely to generate useful data for comparing cross-national and regional patterns in the epidemiological profile of drug abuse.

Emerging issues

Despite considerable progress in improving the methodology of epidemiological data collecting in this field, a number of issues are emerging which planners attending this Seminar may wish to address.

One issue is the rapid proliferation of data collecting instruments as epidemiological and other assessment activities increase on both national and international levels. For this reason the UN Division of Narcotic Drugs and WHO have established the principle of comparability of data collecting for the core items in their various instruments. But the principle of comparability is not an issue to be resolved only by International Organizations; it must be worked through on the country level as well. It is not possible to effectively pool and analyse national data when they are

collected on forms that are unique to each reporting agency. It is important in the early stages of development of a national data system to reach agreement on the core data items to be reported. It is important for the different agencies to report according to a standardized format, not only for reasons of economy and efficiency, but also to facilitate identification of duplicate reports and to permit record linkage.

Another issue stems from the relative ease with which it is now possible to generate large data sets. It is much more difficult to analyse the data so that our findings are directly relevant to the many practical problems confronting national drug abuse programme planners and policy makers. During the coming week we may be asking ourselves whether our respective assessment activities are helping: (1) to clarify the extent and characteristics of the drug using population in our community; (2) to facilitate early identification of new drug use patterns and trends, and new populations of users; (3) to contribute to better understanding of the basic causes of endemic and epidemic types of drug abuse; (4) to evaluate the impact of prevention, treatment and other intervention measures; (5) to illustrate the ways in which epidemiological information can contribute to the design of more effective prevention and treatment programmes.

It is apparent that countries with large and serious problems of drug dependence, tend to see the need for some form of national data bank, reporting or registration system. But these systems can be expensive and requests for the necessary resources must compete with other national priorities. We must be sure then, that they are generating useful information, and that systems now under development can benefit from the experience and technology of already established data systems.

There is need for increased cooperation between technical experts attending this Seminar and from other countries in the region to help one another find solutions to common problems. There is need to suggest ways in which WHO and other International Organizations can facilitate your work through technical cooperation. It would be of particular use to the WHO Research and Reporting Project if you were to identify the need for data collecting methodologies that are not now currently being addressed.

It will be possible to draw meaningful conclusions from our assessment activities, only to the degree that our data are reliable and valid. But our task is not an easy one, as drug abusers are frequently seen as unreliable and some may have reason to distort information when their drug use is stigmatized or punished. perhaps some of the participants in the Seminar have developed simple procedures to increase reliability and validity which can be included in epidemiological studies wherever possible, for example, collecting of urine samples from subjects for analysis of their drug content.

The coming together of key drug abuse experts in this region along with their data, may permit new insights into such issues as why heroin appears to be spreading among urban youth in some countries of this region,

while other countries in close geographic proximity, may be spared. Are the preventive efforts more effective in the spared countries, or do their data merely not reflect the real size of the problem? Have we learned enough about the course of such epidemics to tell us how we might intervene to bring them to an earlier termination? Can they be detected early enough and responded to effectively enough to prevent them from running their socially destructive course.

This week we are fortunate in gathering together at this Seminar, experienced technical experts who can address these and other important issues confronting all of us. Your conclusions and recommendations will be of considerable interest to WHO and other International Organizations in helping to guide the future direction of their programmes. It is hoped that these discussions will help clarify for all of us, how we can improve our respective contributions to knowledge in this important area of research, and how we can more effectively work together toward a common goal of assessment and reduction in the demand for illicit drugs in this part of the world.

ACKNOWLEDGEMENT

The author gratefully acknowledges the contributions of the following collaborating investigators on the WHO Research and Reporting Project on the Epidemiology of Drug Dependence:

Professor A. Anumonye, College of Medicine, University of Lagos, Lagos, Nigeria

Mr Lee Boon Aun, Centre for Policy Research, Universiti Sains Malaysia, Penang.

Dr Chitr Sithi-amorn, Chulalongkorn University, Bangkok, Thailand.

Mr R. Cutler, Water Street Research Group, Vancouver, Canada.

Dr L. Johnston, University of Michigan, Ann Arbor, Michigan, USA.

Dr U. Khant, Rangoon Psychiatric Hospital, Rangoon, Burma.

Ms. Maria Elena Medina Mora, CEMEF, Mexico City, Mexico.

Dr V. Navaratnam, Centre for Policy Research, Universiti Sains Malaysia, Penang.

Dr P. Renault, National Institute on Drug Abuse, Rockville, Maryland, USA.

Dr R. Salan, Directorate of Mental Health, Ministry of Health, Djakarta, Indonesia.

Dr M. Shafique, Khyber Medical College, Peshawar, Pakistan

Dr R. G. Smart, Addiction Research Foundation, Toronto, Canada.

Dr V. K. Varma, Postgraduate Institute of Medical Education & Research, Chandigarh, India.

Dr Vichai Poshyachinda, Chulalongkorn University, Bangkok, Thailand.

Mr K. A. Wadud, Pakistan Narcotics Control Board, Islamabad.

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[2]Wld Hlth Org. techn. Rep. Ser., 1973, No. 526

[3]WHO Regional Office for the Western Pacific (1976) Early Intervention Programmes in Drug Abuse, Manila (ICP/MNH/001, a report on a Working Group)

[4]The Universiti Sains Malaysia Drug Abuse Research Project in fact, will be playing a major role in analysis of collaborative data generated in a study on the evaluation of drug dependence treatment methods in 1978 and 1979.

[5]WHO Meeting of Collaborating Investigators on Epidemiological Case Reporting of Drug Use (1977), Geneva (MNH 78.5 Report on Meeting)

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[7]WHO Meeting on Control of Psychotrophic Substances: With Special Reference to Social and Public Health Problems (1978) Geneva (MNH 78.12 Report on Meeting).

SHORT CASE REPORTING FORM

ID INFORMATION (for country or WHO use) ___ REPORTING UNIT ___ CASE IDENTIFICATION No. ___ CARD No. ___

DATE OF REPORT Day ___ Month ___ Year ___ SUBJECTS; SEX 1 ☐ Male 2 ☐ Female DATE OF BIRTH Day ___ Month ___ Year ___

Column Number 1-12 | 13-25

DRUG USE PATTERN	DRUG USE IN LAST 12 MONTHS			If drug use; FREQUENCY OF USE LAST 30 DAYS (circle one appropriate answer)						MOST RECENT ROUTE OF USE							YEAR OF FIRST USE to be completed for ALL DRUGS EVER USED	
DRUG CODE	No	Yes	Don't know	not used last 30 days	Less than once weekly	Once weekly or more	Once daily	Two-three times daily	Four or more times daily	Don't know	Eat/drink	Smoke	Inject	Sniff	Other ways	Don't know		
___ CODE ..... Drug name	1	2	9	1	2	3	4	5	6	9	1	2	3	4	5	9	19 ___	26-32
___ CODE ..... Drug name	1	2	9	1	2	3	4	5	6	9	1	2	3	4	5	9	19 ___	33-39
___ CODE ..... Drug name	1	2	9	1	2	3	4	5	6	9	1	2	3	4	5	9	19 ___	40-46
___ CODE ..... Drug name	1	2	9	1	2	3	4	5	6	9	1	2	3	4	5	9	19 ___	47-53
___ CODE ..... Drug name	1	2	9	1	2	3	4	5	6	9	1	2	3	4	5	9	19 ___	54-60
___ CODE ..... Drug name	1	2	9	1	2	3	4	5	6	9	1	2	3	4	5	9	19 ___	61-67
___ CODE ..... Drug name	1	2	9	1	2	3	4	5	6	9	1	2	3	4	5	9	19 ___	68-73
___ CODE ..... Drug name	1	2	9	1	2	3	4	5	6	9	1	2	3	4	5	9	19 ___	

PRIMARY DRUG OF ABUSE AT PRESENT (enter appropriate drug code from above, if unknown enter 99) ___

INFORMATION ON PRIMARY DRUG OF ABUSE VERIFIED BY: (circle only the code for the most important source of verification)

CODE
1 Medical examination or diagnosis
2 Urine test
3 Record of drug related arrests
4 Staff observation
5 Other means, specify .....
6 No verification made

b ___ 74-77

78-80

___ DRUG CODE

Form completed by ..... print name

DRUG LIST

DRUG CODE	
00-09	**OPIATES**
00	Opiates, general
01	Opium
02	Heroin
03	Methodone
04	Pethidine
05	Morphine
06	Codeine
07	
08	
09	Unknown opiate
10-19	**CANNABIS**
10	Cannabis, general
11	Hashish, charas
12	Marijuana, ganja
13	Bhang
14	Hashish oil
15	
16	
17	
18	
19	Unknown cannabis
20-29	**COCAINE**
20	Cocaine, general
21	
22	
23	
24	
25	
26	
27	
28	
29	Unknown cocaine
30-39	**HALLUCINOGENS**
30	Hallucinogens, general
31	LSD
32	Mescaline, Peyote
33	
34	
35	
36	
37	
38	
39	Unknown hallucinogen
40-49	**AMPHETAMINES**
40	Amphetamine, general
41	
42	
43	
44	
45	
46	
47	
48	
49	Unknown amphetamine
50-59	**SEDATIVE HYPNOTICS**
50	Barbiturates, general
51	
52	
53	
54	
55	Non-barbiturates, general
56	Methaqualone
57	
58	
59	Unknown sedative hypnotics
60-69	**TRANQUILIZERS**
60	Tranquilizers, general
61	Clordiazepoxide HCl, Librium
62	Diazepam, Valium
63	
64	
65	
66	
67	
68	
69	Unknown tranquilizers
70-79	**INHALANTS**
70	Inhalants, general
71	Glue
72	Paint thinner
73	
74	
75	
76	
77	
78	
79	Unknown inhalant
80-89	**ALCOHOL**
80	Alcohol, general
81	Whiskey, spirits, hard liquor
82	Wine
83	Beer
84	
85	
86	
87	
88	
89	Unknown alcohol
90-99	**OTHER DRUGS**
90	Other drugs, general
91	
92	
93	
94	
95	
96	
97	
98	
99	Unknown other drug

RECENT ACTIVITIES OF THE UNITED NATIONS IN DRUG ABUSE ASSESSMENT[1]

By

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UN Division of Narcotic Drugs
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On the basis of the annual reports submitted to the United Nations Division of Narcotic Drugs by States parties to the international drug control treaties and other information available to the United Nations and specialised agencies, the secretariat analyses systematically the extent, patterns, trends and other characteristics of drug abuse by regions of the world, relevant for the formulation of international drug abuse control policy. Such information is the basis for the preparation of an annual report on drug abuse for consideration by the U. N. Commission on Narcotic Drugs, a policy making organ in the field of drug control.

Main features of recent patterns and trends of drug abuse in the world

I would now like to outline some of the main trends and patterns of drug abuse in the world. Unfortunately, all available indicators show still an increasing trend of drug abuse and its associated problems. The abuse of heroin and other narcotic drugs, as well as psychotropic substances such as amphetamines and methaqualone, had continued to expand in most parts of the world. Traditional drug abuse still persists and prevails as a severe problem in many countries. Cocaine abuse had expanded, primarily in the Americas and, to a lesser extent, in Europe and other regions. Hallucinogens, mainly LSD, are abused in many countries, although the magnitude of the problem seems to be less marked; however, augmented abuse of phencyclidine in North America gave cause for concern. Cannabis continues to lead as the most widely abused drug throughout the world. Multiple drug abuse is emerging as the principal pattern of drug taking. There is a tendency to use more potent drugs and to change the mode of drug taking, such as from oral to injection.

I wish now to bring to your attention some of the principal features of drug abuse in the different regions of the world.

In **Africa**, cannabis is the most widely abused drug. While in a number of countries it is traditionally consumed by persons of different ages, the abuse of cannabis, frequently in combination with other substances, has spread in recent years among youth in urban areas. Extended abuse of

[1] The author wish to express his gratefulness to Professor G. M. Ling, Director Division of Narcotic Drugs, who has substantially contributed to the preparation of this paper by his comments.

psychotropic substances, such as amphetamines and sedative-hypnotics, as well as a growing tendency towards multiple drug abuse, is another important characteristics of drug abuse in many countries of this region.

Cannabis is the most widely abused illicit drug among young people in the **Americas** showing an increasing trend in many countries of the region. Addiction to heroin and other opiates is still a serious problem in North America though it shows a tendency to remain stationary. A number of countries have reported augmented abuse of cocaine, amphetamines, sedative-hypnotics as well as a rising tendency towards the taking of two or more substances in combination. The large number of people chewing coca leaves is still a grave socio-economic and public health problem for some Andean countries of South America.

A number of countries of **Asia and the Far East** are confronted with serious problems of opiate addiction, characterized primarily by a continued increasing spread of heroin abuse among young people in urban settings. Concurrently, traditional opium consumption prevails among middle-aged and older people in the lower income groups, principally in villages. Expanded abuse of non-barbiturate sedatives, barbiturates, amphetamines and tranquillizers, as well as a growing tendency towards multiple drug abuse, are also emerging features of drug abuse in this region.

Most countries of Europe are confronted with an augmented abuse of heroin and other opiates, predominantly by young persons. This trend is followed by an enlarged number of deaths due mainly to heroin injection. Abuse of amphetamines, non-barbiturate sedatives, tranquillizers and barbiturates is also on the increase in many countries. Cannabis continues to rank as the most frequently abused drug among adolescents. As in other regions, two or more psychoactive substances are frequently taken in combination.

Opiates and cannabis are the major drugs of abuse in the **Near and Middle East.** Opium addiction, traditionally rooted in many countries, still remains prevalent among middle-aged people mainly in villages, while heroin addiction has spread in one country among young persons in urban areas. Abuse of Psychotropic substances has also expanded in a number of countries of this region.

Abuse of opiates, mainly heroin and synthetic narcotics, often taken in combination with other substances, constitutes a considerable problem in **Oceania.** Moreover, abuse of amphetamines and other psychotropic substances and the widespread abuse of canabis add to the problem in this region.

It is also worth noting some of the problems frequently associated with drug abuse in all regions of the world such as impairment of physical health including death in some cases, impairment of mental and psychomotor functioning, disturbance of psychosocial maturation during childhood and

adolescence, reduction in school or work performance, deterioration of family and social relationships, violent behaviour, involvement with crime, accidents, increased social cost and other serious problems.

Manual on Drug Abuse Assessment: Use of existing data

I would now like to inform you on some of the activities of the Division of Narcotic Drugs in preparing instruments for drug abuse assessment. In view of the difficulties experienced by government authorities in assessing the characteristics of drug abuse needed for appropriate designing and implementing of intervention programmes in their respective countries, the United Nations Division of Narcotics Drugs has drafted a Manual[2] on the use of existing data for drug abuse assessment in a community. The practicability of this Manual is being tested through pilot studies in a number of countries. It should be noted in this respect that the results of the pilot studies carried out in Malaysia by Dr. V. Navaratnam and his colleagues and in the Philippines by Mrs. Estela Ponce and her colleagues contributed substantially to the preparation of the Manual. On the basis of these studies and those conducted in other countries, the Manual will be finalised for publication this year.

The Manual is designed to collect data through different agencies or services in a community (health, welfare, law enforcement, schools) which, for reasons such as treatment, advice, or drug offences, come in contact with persons who abuse drugs. Provided confidentiality and anonymity are preserved, the records available in these agencies can be used to make a reasonable estimate of the patterns, trends and other characteristics of drug abuse needed for the formulation of policy in drug abuse control.

To assist in collecting comparable data from the different agencies, a Form of one page has been devised for recording information obtained from a person during his/her contact with any such agency. This Form has been prepared as a simple instrument so that it can be filled in easily, even by persons who have no special skills in record keeping. It contains only the core items necessary for answering such questions as: what kind of drugs are abused and where? What are the main characteristics of persons abusing drugs? What are the new patterns and trends of drug abuse? An attempt was made to prepare the Form in such a manner so that the data could be analysed and interpreted easily, thus permitting a continuous feedback of information. Instructions are given in the Manual to ensure uniformity of record keeping.

There are three steps to be undertaken in implementing the Form. First, to define the community (country, etc.) for which data are to be collected. Second, to identify the agencies or services which come in contact with persons abusing drugs to facilitate such identification, eleven schedules have been designed in the Manual for different types of agencies

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2 United Nations Division of Narcotic Drugs Draft Manual on Drug Abuse Assessment — Part One.

(health, welfare, school, occupational, etc.). The third step would be to obtain the agreement of the identified services to collaborate in the data collection.

This procedure has, however, some limitations. For example, information on drug abuse can be obtained only from those persons who come in contact with an agency. They are usually persons for whom drug taking has resulted in an expressed need for intervention. Thus, experimental and occasional drug users have less chance of being included in the data collected. The availability of data will also depend on the extent to which services are provided for persons abusing drugs by the various institutions in a community.

Once developed, a system of continuous reporting will, however, be extremely useful in keeping decision makers in constant touch with the drug abuse scene, showing the changing patterns and current trends of drug abuse, giving early warning on the use of new drugs and identifying those abusing such drugs.

Despite the limitations of this procedure such as those outlined above, it has the advantage that, at low cost, it can be used to obtain essential data, on the basis of which a reasonable estimate of the extent, patterns and trends of drug abuse in a community can be made.

Manual on the use of survey methods in drug abuse assessment

The Division of Narcotic Drugs has also drafted a Manual[3] on the use of survey methods for assessing drug use and abuse in both general population and specific population groups. It describes the advantages and limitations of different sampling procedures for selecting persons either to be interviewed according to the standardized schedules described in the Manual or to be administered a self-reporting questionnaire, both for the purpose of measuring the patterns of drug taking. This Manual has been pretested on a small scale and it will shortly be ready for pilot testing in different countries.

It should be mentioned here that there are some common difficulties in assessing the drug abuse at either national or local level. The limitations of available and relevant data constitute the main difficulty in most countries. This difficulty is not only inherent in drug abuse but is also rather common to many human pathological problems, particularly those with serious social implications. The problems encountered are still connected with the definition of various terms such as drug use, abuse, addiction, dependence, etc.

Drug abusers often change the amount, frequency or mode of drug taking, switch from one drug to another or use more than one drug, which altogether complicates data assessment. Some other methodological difficulties should also be considered. For example, so far no single technique is known to be sufficient for determining complete and accurate figures of prevalence and incidence of drug abuse. Morever, circumstances

3 United Nations Division of Narcotic Drugs Draft Manual on Drug Abuse Assessment — Part Two.

may differ considerably from one part of a country to another with respect to urban, rural, socio-cultural, economic, drug pattern and other pertinent factors.

Each of the available methods or techniques for data collection may, primarily, with respect to local circumstances and characteristics of population, have its advantages and limitations. However, the limitations of a given technique do not necessarily mean that it is without value for assessing the problem of drug abuse in a population. What is important is to recognize both the strength and limitations of different procedures which could be used for data assessment in a given community and, on this basis, to select those which may prove most suitable. The socio-cultural and other relevant factors of a situation, as well as expected benefit-to-cost ratio should be thoroughly considered when weighing the value of a technique to be implemented. Thus, data on drug abuse should be collected in a way which would best suit the possible data resources of a population in a given area. The synthesis of data derived from different sources can make it possible to estimate the extent, trends, patterns and other characteristics of drug abuse in a population.

In order to make data as comparable as possible, an effort should be made to standardise procedures and to work out operational definitions of terms which are frequently used.

Concerning the comparability and the amount of data required, an investigator must ask a question to what extent and at what expense these could be achieved? The objectives of an assessment should however determine these as well as other significant component of data collection.

In concluding this presentation, I wish to express the hope that the results and recommendations of this workshop will provide a better understanding of the role and possibilities of realistic use of assessment in determining the nature of the problem of drug abuse and in designing and implementing social programmes and actions which should best respond to the changing needs for intervention in a given community. To this end the workshop may find appropriate to consider the following questions:

(1) How can the magnitude of drug abuse and its change over a period of time be effectively measured at a reasonable cost.

(2) How can assessment help appropriate designing and implementing of preventive and other social intervention programmes.

(3) How can assessment be used in the evaluation of effectiveness of treatment and other measures aimed at reducing illicit demand.

(4) Can assessment provide a feed back mechanism between the policy making and the existing needs for intervention in a community, and if so, by which instruments and at what cost it could be accomplished.

HONG KONG NARCOTICS REGISTER SYSTEM

By

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BACKGROUND

The Central Registry of Drug Addicts was set up in April 1972 on the recommendation of the Action Committee Against Narcotics (A. C. A. N.) *. It has been administrated by the Narcotics Division of the Government Secretariat, with the support of the Census and Statistics Department, which provides statistical advice, and the Data Processing Division of the Government Secretariat, which processes and analyses the data collected. Its original objectives were:-

(a) to estimate the total number of drug addicts in Hong Kong.

(b) to obtain information on the average success rate for institutionalized treatment, and

(c) to compare the success rate of organized treatment with that of other form.

2. All agencies likely to have contact with drug addicts, including law enforcement, treatment, welfare agencies, and hospitals were requested to complete a standard form on contact with each drug addict. Reporting was entirely voluntary. Completed forms were collected regularly by the Registry, which, after checking and coding, referred them to the Data Processing Division and the Census & Statistics Department for processing and analyses.

3. Between 1974 and 1975, the C. R. D. A. published two statistical reports, outlining the characteristics of local drug addicts and the results of certain treatment programmes. However, after 3 years of operations, problems concerning the reliability of data, the efficiency of the matching system and the realism of the objectives became obvious.

4. In January 1975, Dr. R. G. Newman of New York City, visiting consultant to the Medical and Health Department, was invited to make an initial diagnosis on the operation of the C. R. D. A. After studying the system in operation, he concluded that the system would not be of value

* The Action Committee against Narcotics (A. C. A. N.) is a permanent nonstatutory body set up to be the sole advisory instrument of the Hong Kong Government on all policy matters relating to the eradication of drug trafficking and drug abuse and the allocation of resources. It also gives recommendations on subventions granted to various voluntary agencies.

unless drastically modified. He recommended that further advice should be obtained and suggested that the services of Mr. Bent Werbell, then Project Manager of the Data Processing Department of the New York City Department of Health, be sought.

THE WERBELL CONSULTANCY

5. With funding from N. I. D. A. of the United States, Mr. Werbell spent three and a half months in Hong Kong in 1976. After studying the system in detail, he concluded that the limitations were too serious to be rectified and, accordingly, recommended a new system involving changes in aims, organisation and operation of the Registry. The following is a brief description of his recommendations:-

(a) Objectives

As recommended by Mr. Werbell, the objectives of the reorganised Registry are as follows:

- to identify trends in the nature of addiction and the addict population in Hong Kong over time.
- to describe certain characteristics of the reported addict population, and to constrast these characteristics among addicts reported from specific sources,
- to provide information regarding the association of contact with certain reporting sources (e.g. law enforcement and treatment agencies) with subsequent, as well as preceding history of addicts.

(b) Organization

The establishment of the Registry should be strengthened by two sub-professional statistical staff, in addition to the officer-in-charge, an Executive Officer. A professional statistician from the Census and Statistics Department assisted by these officers would determine the data required from the Registry and the kind of reports to be produced. To maintain the computer system of the Registry, one programmer/ analyst and one key punch operator posts should also be created in the Data Processing Division of the Government Secretariat.

(c) Data Collection System

Appendix I

A new one-page record sheet (Appendix I) was designed to replace the existing one for distribution to reporting agencies. The form, in Chinese and English, collects identifying, social, demographic and drug abuse information for each individual addict or suspected addict whenever an agency makes contact with him/her. Briefly, the C.R.D.A. divides its reporting sources

into two broad categories, i.e. treatment and non-treatment agencies. In respect of treatment agencies, a report is required **both** when the individual applies for and is admitted to treatment in respect of non-treatment agencies, a report is required only upon initial contact. In addition to the above, re-admission or re-opened cases are to be regarded as new cases and new reports are required. Guidelines explaining when and how a report is to be completed, are at Appendix 2.

Appendix 2

(d) **Data Preparation**

Each reporting source sends all completed record sheets to the Central Registry on a monthly basis. The Registry staff then checks and edits each report before it is keyed into the computer system where it will be further edited for logical, key punch and content errors. The C.R.D.A. staff then receives a complete error report which is used to correct the input data.

(e) **Matching Procedure**

Appendix 3

All accepted input record sheets are then checked against the entire Registry Data Base to attempt to match each report with previously known cases, according to the preassigned matching criteria (Appendix 3). The system produces three main listings (i.e. definite matches, probable matches, and definite non-matches) that need to be carefully studied by the C.R.D.A. staff who then return information to the system specifying which probable matches have been found to be definite matches. and to which individual case they should belong. All probable cases not so specified are treated as new cases by the system. The third listing contains the records which are definitely not matched to any previous case.

(f) **Production of Statistical Reports**

After the monthly input is processed by the computer system, various statistical trend reports are produced. These reports provide the following types of information:-

(i) **Incidence and prevalence rates and their trends**

Such data will be valuable in forecasting the demand for treatment facilities and for law enforcement action.

(ii) **Age, Sex, drug abuse pattern and geographic breakdown of the addict population and their trends**

(iii) **Subsequent or preceding reporting history**

Information of this kind will be an important contribution for the evaluation of treatment programmes. The Registry will be in a unique position to determine the likelihood of an addict having contact with, for instance, the Police during specific intervals following/preceding admission to different treatment programmes. For example, all individuals admitted to a specific treatment programme in 1977 would be analysed to determine how many patients were subsequently/previously reported by the Police 6 months after/before admission, or 12 months after/before admission, etc. Another treatment programme would then be analysed to make a comparison possible.

(g) **Confidentiality**

A complete guarantee of anonymity for ex-addicts, current addicts and non-addicts is absolutely essential. Demands for identifying information regarding an individual should be refused without any exception.

IMPLEMENTATION OF THE NEW REGISTER SYSTEM

6. Mr. Werbell's report was submitted to the A.C.A.N. in August 1976 and his recommendations were accepted by the Committee. Implementation of the new register system involves two phases. **Phase one**, which was started on 1st September 1976 introduced a new data collection system; it also modified the organisation and objectives of the Registry. So far, the C.R.D.A. has received about 50,000 records from 21 agencies, comprising more than 90 reporting sources. **Phase two,** involving the development of a computerised data processing system, began in August 1977. The system is being tested and it will be in full operation in July 1978

7. Regarding the confidentiality of records, legislation is being considered which would restrict the disclosure of identifying information related to reported individuals.

C. R. D. A. MATCHING SYSTEM AND ITS PROBLEMS

8. One of the failures of the old C. R. D. A. system was its inability to match efficiently newly entered records with existing ones so as to identify duplications; the main reason being that identifying information provided by individual addicts is often unreliable.

9. To determine whether a person has previously been reported, the Hong Kong Registry relies mainly on three pieces of identifying information, namely, the name/alias, the identity card number, and the date of birth. The problems relating to the collection of each of such data are as follows:-

(a) **Name/alias**

The main problem is that the use of aliases is common amongst Hong Kong addicts. An addict, therefore, may report name A to a law enforcement agency, name B to a treatment agency and name C to other agencies. It is extremely difficult, therefore, to determine whether a person has been reported or not, based only on his name/alias. Another problem is that, as many Chinese characters have the same pronounciation. the Registry has to make use of the Chinese character telegraphic codes rather than romanisation to ensure that characters bearing the same sound are distinguished from one another.

(b) **Identity Card Number**

Every legal Hong Kong resident other than children under 10, is required to register for an identity card. Theoretically, therefore, the I.D. card number is a very good piece of identifying information. The problem, however, is that the carrying of the I.D. card is not compulsory and, consequently, many of the reports received by the Registry lack the information. In this respect the treatment agencies have attained a better score as many of them require the production of an I. D. card on registration for treatment. The law enforcement agencies, on the other hand, are not always able to obtain such information as the individuals may not be carrying their I. D. cards upon arrest.

(c) **Date of birth**

When used together with either the name/alias or I. D. card number, the date of birth is also a good means of identification. The problem, however, is that, as local residents are accustomed to use both the western and lunar calendars concurrently, the birth dates given by the individuals on contact may be in either system. Conversion from one calendar to another, while possible, may create confusion as the person may not be reporting the exact date of birth in the first place.

10. Owing to the above difficulties, the re-organized Central Registry has developed a sophisticated matching system. Basically, the system involves the matching of 49 possible combinations of the three above-mentioned information, together with the sex of the individuals. In addition, to supplement the above, two pieces of information, i.e. the place of birth and the native place of the individuals are also collected.

THE REGISTER SYSTEM IN RELATION TO ASSESSMENT OF DEMAND

11. As mentioned before, the Register does not aim at estimating the size of the addict population. This figure is not only impossible to obtain, but such estimates are not really directly relevant for planning purposes, although they are, of course, of great public interest. Instead, the Registry attempts to answer the following questions:-

(a) How many **new** addicts or suspected addicts are reported at each time interval?

(b) What are the age and geographic distributions of these **newly** reported individuals and how have the distributions changed over time?

(c) What types of reporting sources do these **newly** reported individuals first have contact with (e. g. law enforcement agencies or treatment programmes) and how does the initial contact pattern change over time?

(d) What is the **total number of individual addicts** known to the Registry at each time interval?

(e) What are the general characteristics of the **total number of individual addicts** and the types of reporting sources with which they are in contact? What are the trends?

12. The trend analysis of (a)-(e) above will provide valuable information to those responsible for policy formulation and the development of anti-narcotics programmes in all fields. It will enable government planners and voluntary agencies to focus more rationally on areas (whether in law enforcement, treatment and rehabilitation, or education and prevention) where the need is greatest.

CONCLUSIONS

13. As mentioned previously, the new C.R.D.A. is not yet in full operation. When statistical results are available in august, a clearer picture of the drug abuse scene in Hong Kong will be available, thus assisting A. C. A. N., the relevant government departments and the voluntary agencies to plan their anti-narcotics efforts more efficiently.

14. Hong Kong is well aware that no one territory or country can solve its drug tracking and abuse problems by itself. We are therefore fully in support of the United Nations and its agencies, the Colombo Plan and all countries whose problems are similar to, or linked with our own, in pursuing international cooperative efforts to deal effectively with this evil scourge. In this spirit, we shall be delighted to make available to all who are interested, details of our research into our drug problems, the methods we use, the findings obtained, and the action which stems from them. We shall also be very glad to welcome to Hong Kong, in the future as in the past, all those from your countries who would find it useful to investigate our work and experiences on the spot. We would, similarly hope to learn from your experience in dealing with your drug problems. We feel, in short, that each of us has much to contribute to the other.

APPENDIX I

CENTRAL REGISTRY OF DRUG ADDICTS
RECORD SHEET

IN CONFIDENCE

Note Tick (✓) correct answer for multiple-choice questions

1 Date of Contact

☐☐ day ☐☐ month ☐☐ year

2. Source of Report :

Leave blank ☐☐☐☐

Dept./Agency _____ Office/Branch _____

3. For Treatment Agencies only - Type of Contact : [1] Application [2] Admission

4. Name (in Chinese characters or English if non-Chinese)

_____

5. Leave blank : ☐☐☐ ☐☐☐☐ ☐☐☐☐ ☐☐☐☐

6. Alias/nickname (in Chinese characters or English if non-Chinese)

_____

7. Leave blank ☐☐☐☐ ☐☐☐☐ ☐☐☐☐ ☐☐☐☐

8 Identity Card No. : ☐☐-☐☐☐☐☐☐

9 Sex : [1] Male [2] Female

10. Date of Birth : Give Western Calendar, if not available give Lunar Calendar

☐☐ day ☐☐ month ☐☐ year

Estimated age _____ Cycle/Animal _____ Lunar Month _____

11. Place of Birth : [1] Hong Kong [2] Outside Hong Kong [3] Unknown

12. Native Place : (in Chinese characters, give 'hsiang' (鄉) also if available e.g. 南海 九江)

yuan (縣) : _____ hsiang (鄉) : _____

13. Education :

[1] None
[2] Yes ☐☐ (specify no. of years)
[3] Unknown

14. Vocational Training :

[1] None
[2] Yes ☐☐ (specify no. of years)
[3] Unknown

15. District of Residence :

[1] Hong Kong Island
[2] Kowloon Peninsula
[3] New Kowloon (north of Boundary Street)
[4] N. T. including outlying islands
[5] Marine (floating population)
[6] Unknown

16. Primary drug of abuse over last 4 wks. (✓ one)

[1] Opium
[2] Heroin
[3] Morphine
[4] Methadone
[5] Amphetamine
[6] Barbiturate
[7] None
[8] Unknown
[9] Other _____

17. Secondary drug(s) of abuse (✓ one or more)

[1] Opium
[2] Heroin
[3] Morphine
[4] Methadone
[5] Amphetamine
[6] Barbiturate
[7] None
[8] Unknown
[9] Other _____

18. Usual method of taking primary drug (✓ one)

[1] Injection
[2] Smoking (through cigarettes or pipe e.g. ack-ack gun)
[3] Fume inhaling (e.g. chasing the dragon)
[4] Oral ingestion
[5] None
[6] Unknown
[7] Other _____

19. Age first used illicit drug : ☐☐

20. Did illicit drug use begin in Hong Kong? [1] Yes [2] No [3] Unknown

21. Previous Addiction Treatment? [1] Yes [2] No [3] Unknown

22. Previous conviction? [1] Yes [2] No [3] Unknown

23. Lawfully employed over last 4 weeks? [1] Yes [2] No [3] Unknown

DO NOT WRITE BELOW THIS LINE

Tick one : 1 2 3 4 5

Only for Corrections ☐☐☐☐☐

Register No. _____ Date Received _____ Action Code Case Number

APPENDIX II

Central Registry of Drug Addicts

Guidelines for filling in the Record Sheet

I. General procedures in filling the record sheet:

1) Please report all **known** addicts as well as **suspected** addicts.

2a) **For treatment agencies (see footnote 1) other than hospitals, sanatoriums and private practitioners:** reports are to be filled on application and **again** on admission of the client unless the two procedures occur on the same day, then only one report, indicating admission is required. Agencies offering more than one type of treatment programme should fill in a new report whenever a client switches from one type of treatment programme to another (e. g. from methadone maintenance to detoxification in the MHD). All re-admissions are to be treated as new cases i. e. treated the same way as for persons not previously enrolled.

2b) **For hospitals, sanatoriums and private practitioners**

- in respect of patients applying for or receiving drug addiction treatment, reports are to be filled in accordance with paragraph 2a above (procedure for treatment agencies)

- in respect of patients suspected to be drug addicts, but **not** applying for nor receiving drug addiction treatment, reports are to be filled in accordance with paragraph 3 below (Procedure for non-treatment agencies)

3) **For non-treatment agencies (see footnote 2):** reports are to be filled whenever a contact is made with an addict or suspected addict (e.g. upon an arrest/rearrest for the Police and upon the initial contact/interview with social workers/probation officers). All reopened cases are to be treated as new cases i.e. treated the same way as for persons not previously contacted/interviewed.

4) For items (1) (8) (10) (13) (14) & (19) where answers are to be given in numbers in the boxes provided, the number should be right-adjusted.

e.g. - for 3rd May 1976, the entry should be .. | | 3 | day | | 5 | month | 7 | 6 | year

- for ID Card number DO 12322, the entry should be .. | D | — | 0 | 1 | 2 | 3 | 2 | 2 | — | |
- for old style juvenile ID card number A-01234 (1), the entry should be .. | A | — | 0 | 1 | 2 | 3 | 4 | — | 1 | 1 |

5) Most of the items in the record sheet are self-explanatory. Further explanations are described in section II below.

6) There is NO need to fill both sides of the record sheet. Fill information on the English or Chinese version as preferred.

7) Fill the record sheets as accurately as possible and forward the completed forms to the Central Registry of Drug Addicts of the Narcotics Secretariat within the **first 7 days** of each month.

8) In case of doubt, please contact the Registry staff. (Tel. No.: 5-95354)

II. Further Explanation to certain items in the Record Sheet

Item 1) This means the date of the contact made between the addict/suspected addict with your department/agency and NOT the date when the Record Sheet is filled although it **could be** the same day.

10) An example of "Date of Birth" according to the Lunar Calendar would be:

50		5th
Estimated age	Cycle/Animal	Lunar month

If the Year of Birth is given in "Minkuo" years, the year in **Western Calendar** can be obtained by adding 1911 to the "Minkuo" year quoted, e. g. the year of birth in Western Calendar of a person born in "Minkuo 15 years" is 1926 (1911+15).

12) For non-Chinese addicts/suspected addicts, leave the item blank.

13) This means schooling received in an educational institute. Attendance of private tutoring classes or nurseries are **not** regarded as schooling.

14) This means formal vocational training in technical or other institutions or under apprenticeship in respect of trades which need particular knowhow, e. g. building, printing, shoemaking, vehicle repairing, tailoring, carpentry, plumbery.

15) Boundaries of Kowloon, New Kowloon and the New Territories are shown in the attached sketch.

16 & 17) Methadone and other drugs obtained from treatment and other authorized agencies are not regarded as "drugs of abuse", e.g. A person taking only methadone from a treatment agency and nothing else is not considered as abusing drugs. Entries to items (16) (17) and (18) should therefore all be "none". However, if he takes

heroin **in addition** to the licit methadone, then heroin should be considered as his primary drug of abuse and entries should be made accordingly.

18) "Usual method" here means "the most frequently used method" in taking the primary drug specified at item (16).

For Prisons Department's Institutions only

If the prisoner has been remanded prior to sentencing, the period of 4 weeks referred to at items (16) to (18) and (23) means the 4 week period before he was taken into custody.

19) This refers to the age the very first time illicit drug is used and **not** the age the person becomes addicted.

21) "Addiction Treatment" refers only to treatment received from "treatment agencies" listed in Footnote 1.

23) A person is considered as "lawfully employed" if the trade engaged is not illegal, i.e. illegal occupation like prostitution, gambling stall worker, drug pusher, etc. are excluded. Casual workers who are only partially employed, shop owners, housewives, etc. would come under "Lawfully employed". Studentship is **not** considered as an employment.

Footnote 1:

This would include agencies like SARDA, DATCs, hospitals, sanatoriums, private practitioners, methadone treatment clinics and other religious/spiritual treatment by organized bodies.

Footnote 2:

This would include agencies like Police, SWD, all voluntary social service agencies, and all Prisons Department's Institutions except DATCs.

Narcotics Secretariat.
November, 1976.

Matching Criteria

Definite matches

(a) ID-number; CCC-code * of name (or alias); birth month; birth year; sex;

(b) ID-number; CCC-code of name (or alias); birth month; birth year - 1 (or+1); sex

Probable matches

(a) ID-number;

(b) CCC-code of name (or alias); birth month; birth year (or birth year - 1 or+1); sex

(c) CCC-code of name (or alias); birth month; sex;

(d) CCC-code of name (or alias); birth year (or birth year$\pm$2 or$\pm$1); sex

Definite non-matches

Reports which do not find a match using the above definite and probable matching criteria are added to the Register Data Base as new cases.

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* CCC - code is a coding system which translates each Chinese character into a unique 4-digit code.

NATIONAL MENTAL HOSPITAL REPORTING PROGRAMME— SOME TRENDS IN THE NUMBER AND CHARACTERISTICS OF DRUG USERS IN INDONESIA, 1972-1977

By

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For almost eight years now it seemed that the drug abuse problem especially among the Indonesian young living in urban regions was still on the rise. Reports from law enforcement agencies, data from hospital statistics and observation by doctors and youth workers reported this trend (1, 2, 3). Since the beginning of this problem massive newspaper coverage and mass-communication time was given to this relatively new phenomenon in the Indonesian community, which inevitably led to some panic among the public and governmental authorities. No reliable data were available and only rough estimates of the number of drug abusers in the community were issued. These figures were multiplied every following year, and no one at that time knew where this may lead to.

In more rational circles the need was felt for solid data which should be collected at periodic intervals, so as to enable policy makers at governmental level to assess the drug situation in a more appropriate perspective. It was fortunate that the Directorate of mental Health, Ministry of Health, Indonesia was in the process of instituting an extensive information system for mental hospitals in the country during this period (4, 5, 6).

The directorate of Mental Health acted swiftly and instructed all State Mental Hospitals in the country to reserve beds for the treatment of drug abusers, and persuaded private facilities and other psychiatric facilities not under its authority to do the same. These two factors were instrumental in providing a solid basis for reliable data collection which could meet the needs of the moment.

BACKGROUND OF THE PROGRAMME

One of the activities of the Directorate of Mental Health was collection and reporting of data on patients residing in State Mental Hospitals throughout the country. Before 1971 these activities were carried out in a conservative way by receiving tabulated reports from the hospitals, which all were incorporated into one final report comprising all hospitals during a defined period. This way of making reports was felt to be arduous, impracticable, and inflexible, in that no other types of tabulations and analysis could be made than those already compiled by the hospitals. The Directorate of Mental Health saw no other way out except to change the whole recording and reporting system in such a way, that many kinds of reports, tabulations, and analyses could be generated as the occasion demanded.

With those objectives in mind, in 1971 the Directorate of Mental Health embarked upon the institution of a new information system, utilizing modern electronic technology available. A new recording and reporting system was created which in addition to providing easy analysis of data, also offered feedback to the individual hospitals through narrative patient's reports and periodic hospital reports.

METHOD

Data reported in this paper were made available by the institution of an extensive computerized recording system which collected records of every mental patient admitted to psychiatric facilities in the whole country. The project was a cooperative venture between the Directorate of Mental Health. Ministry of Health, Indonesia and the International Committee Against Mental Illness (ICAMI), New York, U.S.A. and was initiated in 1968. Due to circumstances the project started in 1970. Detailed description of the mode of operation, manuals, developments, and results were reported elsewhere (4, 5, 6, 7).

The recording instrument in this system was a multiple choice type questionnaire known as the General Purpose Psychiatric Questionnaire (GPPQ). It contained administrative, socio-cultural, and medical information of the mental patient recorded during intake. In the domain of socio-cultural information recordings were made of name, address, age, sex, place of birth, date of admission, source of referral, environmental background, patient's parents (still alive, divorced, separated, dead, etc) educational level, marital status, employment, housing conditions, religion, and community activities. In the second part of the questionnaire information included: duration of illness, rapidity of the onset of illness, remissions prior to hospitalization, drug or alcohol abuse, intelligence level (clinical estimate), criminal behaviour, convictions, diagnosis, prognosis, and treatment prior to admission. After completion these questionnaires were mailed on a bi-weekly or monthly basis from the hospitals to the Directorate of Mental Health in Jakarta. Data contained in the questionnaire were transferred to keypunch cards and run through a computer. The resulting narrative print-outs were then mailed to each hospital for further use. Periodic statistical reports could easily be produced from the data pool in the computer tapes. By using standardized criteria, based on consensus, fair comparisons of patients in different facilities could be made. Since 1972, 35 facilities joined this project and nearly all mailed data regularly for analysis.

There are 5 basic types of facilities:

1. State Mental Hospitals: These are financed by the Ministry of Health or Provincial Governments. In accordance with their location they provide services for acute as well as chronic patients. They are medium sized units with a capacity of 200-1000 beds and are distributed over most of the Provinces.

2. University Departments of Psychiatry: These facilities provide undergraduate training and in some accredited centres there are facilities for postgraduate training. These facilities are mostly in the major cities like Jakarta, Surabaya, Medan, and Jogjakarta and are small units with approximately 50-60 bed capacity.

3. Private mental hospitals: These facilities are usually set up by psychiatrists and are generally located in the major cities in Java and Sumatra. They are small units with approximately 60 bed capacity.

4. Military Departments of Psychiatry: These facilities are usually units in military general hospitals and provide services for the military and their families.

5. Psychiatric departments in general hospitals: Some general hospitals especially from the private sector have bed capacity for mental patients.

RESULTS AND COMMENTS

TABLE I which shows the total number and sex of patients admitted to the hospitals during 1972-1977 reveals an epidemiological rise. This reached a peak in 1973 followed by a fall to a low level in 1977. The majority of patients were male: a total of 696 (89.5%) males against a mere 81 (10.5) females. Throughout the epidemiological fluctuations the proportion of males to females remained more or less constant. Further examination of data from each hospital during these years offered the same picture. The discrepancy between the number of male and female patients was apparently not related to seasonal or geographical variations, but there seemed to be other factors working which may be inherent to the drug problem in this country. The Indonesian culture is predominantly male oriented. This cultural climate provides greater opportunity for males to seek diversion outside their homes and to associate themselves with peer groups or other bands of youngsters. Girls on the other hand are brought up in more traditional ways and tend to favour a more conservative outlook on life, with the exception of some "modern" few. This would explain the more "contagious" nature of drug abuse among males compared with females. FIGURE I shows the more pronounced epidemiological nature of the drug abuse problem among boys compared with the more "endemic" nature among girls.

The age distribution during this period (TABLE 2) exhibits a total of 450 (57.9%) patients in the 11-20 years and 282 (36.3%) patients in the 21-30 years age group. The distribution of drug dependents is extremely positively skewed towards the younger age groups. But inspection of the trend of this distribution throughout the years reveals some additional interesting findings. FIGURE II illustrates that from 1972-1974 most patients were between 11 - 20 years. Since 1975 a gradual increase in the proportion of drug dependents between 21 - 30 years, was seen, so that in 1976 more older than younger patients were admitted. Although in 1977 a reduction in the proportion of the older patients was seen, it should be reminded that the 1977 proportion should not be taken at

face value, because of the rather small number of patients admitted during this year. The epidemiological surge in 1973 seemed to affect the younger people much more than the older ones, in terms of numbers admitted to the hospitals. But attention should be called to the fact, that the older patients were apparently those who were hooked on drugs for longer periods of time, and as a consequence of that, were the more serious drug abusers. These results indicate that the 1973 young drug users were still in the experimental or casual phase of their habit. They later either turned into older patients really hooked on drugs, or got rid of the habit one way or another. This argument seemed to concur with the experience of clinicians who found that withdrawal symptoms were usually rather mild or absent. The data which provide information on the duration of drug abuse (TABLE 6) confirmed these findings.

Data showed that the drug abuse problem was mainly related to the big cities and the urban regions. Almost 90% of the drug abusers were raised in urban areas (TABLE 3). Data from each hospital confirmed these findings and showed more explicitly that the problem was located in cities like Jakarta and Surabaya. Data recorded from patients in hospitals outside these cities sometimes were from patients arriving from Jakarta and taking up new residences in these locations. The modest rise of drug abusers in suburban areas from 7.9% in 1974 to 23.9% in 1977 seemed to confirm the police reports that the drug abuse problem was spreading into those areas. However, caution should be exercised in comparing data from police reports and data from medical facilities. What is defined as drug abuse by law enforcement people does not necessarily mean the same for those working in a medical setting. Coordinated community surveys would be able to provide valuable complementary information.

Since most of these youngsters were only in their teens when the epidemic struck them, it is not surprising to find that a majority of 609 (78.4%) patients were single and a small number of 99 (12.7%) patients were married (TABLE 4). A negligible number were either separated, divorced or widowed. It is logical that in looking for clues about the causes of drug abuse among these people, marital problems would not provide much information, at least in Indonesia. A more reasonable approach would be to focus for clues in teenage and adolescent problems - problems in education; problems of relationship within the family circle; problems of adaptation to circumstances in the environment; and other related teenage problems - as causal factors. Diligent search by clinicians would be of great benefit. It is only unfortunate that such information can only be superficially covered by the questionnaire method. The fact that the problem encountered by one teenage patient may differ extremely from another patient, is a strong rationale for an individualized approach towards treatment and rehabilitation in drug abuse. Data collection and analysis should play the complementary role of offering information to clinicians so that they can by-pass unimportant aspects and focus intensively on more relevant causal factors.

Obtaining reliable information about income level of patients or their parents in this country had always been a difficult task. Figures such as the amount of earnings did not reflect real income. For evaluation other variables had to be resorted to, e.g. presence or absence of certain signs of wealth at home, occupation of the parents, additional jobs, and other relevant information. Categories presented in TABLE 5 were based on variables like these and could only provide very rough estimates of incomes. Five-hundred and thirty-one (68 3%) patients could be categorized into a medium income level. The high number of patients who either refused to state their income level or were difficult to put in any category because of insufficient infrormation (16.9%) reflected the difficulty of obtaining this type of data. It should be noted in this context that according to clinical experience, during the last years patients from families with low income level were more often admitted than previously. This observation is supported by data on educational level. More patients with low educational level seemed now to be admitted (TABLE 9).

As previously noted, more older drug abusers were admitted since 1975. TABLE 6 which shows data on the duration of illness provides a clarification of this trend. If all the cases from 1972-1977 were added together, the majority of 392 (50.4%) patients had a history of illness quite recently i.e. 1 week - 12 months. However, a different story is revealed in FIGURE III which shows the same data in another perspective. During 1972 and at the height of the epidemic in 1973 the proportion of patients with a history of illness from 1 - 12 months was highest. This aptly located the approximate beginning of the epidemic somewhere between 1972 and 1973. A different picture emerged after 1974. The proportion of drug abusers with a duration of illness for more than 1 year exceeded the proportion of recent drug abusers. These were the older and long-time, serious drug abusers shown in TABLE 2. It seemed that the epidemic pattern in 1973 involved the younger more recent drug users. But the endemic pattern after 1973 related to the long-time and older users. However, another cautionary note should be made. The decrease of the number of drug dependents admitted to hospitals since 1974 was mostly due to the scarcity of narcotics available in the market, because of regular police raids. Drug abusers now turned to other drugs, e.g. sedatives, hypnotics, and sleeping pills. With dependence to these drugs patients were less willing to stay in hospitals, in contrast to heroin and morphine users. Patients dependent on psychotrophic substances tended to seek medical help in outpatient clinics rather than in hospitals. The decrease of the number of drug dependents in hospitals does not necessarily mean also a decrease of the drug dependents in the community.

The pattern of referral did not change considerably during the 6 years period. The bulk of the patients was referred by their families (59%), a smaller proportion by their physicians or a psychiarist (22%), and a much smaller proportion by the police (11.6%). At the peak of the epidemic most patients were referred by their families but later on the medical profession played an increasingly important role, and more patients were admitted through referrals by the medical profession (Figure IV). The stable number of referrals by physicians reflected the durability of the efforts

of the medical profession in providing care to drug dependents. The preference of patients for ambulatory treatment, which was noted before, and which was a more recent development, is another parameter of the involvement of physicians in drug abuse. Although the role of the police in referring patients for treatment seemed to decline, this actually did not reflect the real situation. Many patients caught in raids were treated in police detention homes. Data from detention homes were not made available for analysis.

It is interesting to note that although more than 90% of the population in the country is Moslem, only 52.9% were represented in the population of drug abusers admitted to the hospitals (TABLE 8). On the other hand the Christians (Catholics, Protestants, and other unspecified Christians) were strongly represented (9.3%). This proportion did not change perceptibly and remained more or less constant during the 6 years period.

How were the changes in the educational level during these 6 years? TABLE 9 shows that 424 (80%) patients had an education more than the 6th grade. Out of these, 370 (47.6%) patients had a 10-12 grade education. But when we examine the data along the years (FIGURE V) it is apparent that the epidemiological rise in 1973 affected mostly those with a secondary or high school education, while patients with only an elementary education remained modestly in the background. But with the wane of the epidemic the higher educated drug dependents gradually decreased, while in contrast those with a lower education showed an endemic increment. It is difficult to predict how the drug abuse problem will develop in the future; but these data indicate that Indonesian policy makers should be alerted to the spreading of drug abuse among the less privileged with all its consequences.

Diagnostic categories in the original questionnaire were rather limited and no detailed information on a national scale could be gained about the changes in drug use pattern. But since 1977 a revision in the questionnaire was made which provided space for all diagnostic categories according to the WHO International Classification of Diseases, 8th Revision, Section on Mental Disorders, 1965. A detailed description was given of each diagnostic entity in the Indonesian Glossary of Mental Disorders 1973. This made reliable and comparable statistics about changes in drug use pattern in 1977. It seemed that most patients were multiple drug users with more emphasis on the use of psychotropic substances (hypnotics and sedatives) while morphine and heroin were comparatively less used. TABLE 10 shows that in 1977 the drug problem was still a problem of big cities. Only two hospitals outside Jakarta reported 2 patients in 1977.

Most of the drug abusers were never arrested (TABLE 11) and a very small proportion were arrested once or more. Criminality associated with drug abuse apparently did not as yet constitute a major problem. This does not mean, however, that criminality will not emerge as an important factor in the future. The potentialities for criminality are there: low income level, low educational level, endemic nature of the more serious drug abusers. In addition it should be noted, that clinicians observed

some degree of criminality among several drug users, such as stealing and robbing from parents or close relatives. Criminality of this nature usually do not easily get into police records.

How serious the problem actually was can be seen from the prognosis on admission evaluated by clinicians based on the overall picture (TABLE 12). Most clinicians were rather cautious in stating the prognosis and 54.8% of the patients were regarded as having a guarded prognosis, 28.6% were deemed as having a fair prognosis, and interestingly, only 7.1% were definitely given the verdict of poor prognosis.

CONCLUSIONS

In these data only a small proportion of drug abusers in the community were represented. Only those patients who had the means and the opportunity to seek treatment in hospitals were recorded and analysed. A much larger proportion of drug abusers remained in the community. They may resort to other means of treatment, e.g. visits to private or governmental outpatient clinics, a popular mode of treatment which had developed recently; they may employ self-treatment methods to change the habit; they may seek assistance from traditional healers; or they may choose other more attratcive alternatives. Some of them may be less fortunate and be caught in police raids and be sent to detention homes for treatment. Some others may just remain in the community and stay hooked on drugs. Patients like these cannot be represented in hospital statistics. To venture into making conclusions about drug abusers outside the hospital from these data would be a hazardous exercise.

To be able to tell what happens with the drug abuse victims in the community, how trends and characteristics are, need special investigations. Community surveys could be conducted at periodic intervals and in different geographical regions. Such data could provide more meaningful information about those drug dependents who never reached the hospitals.

What then is the rationale for collecting hospital data regularly and analysing them continuously? Is this not a waste of money and time? Would periodic efforts to assess the situation not be cheaper and as effective? These questions—which are quite legitimate—are often asked by budget conscious policy makers in the government. Hospital data for drug abusers as presented here actually were not collected for drug abusers alone. Collection of these data was only a small aspect of the data gathering effort for all mental patients in hospitals. Since data were gathered throughout the country and processed through electronic equipment within a relatively short time without much additional costs, results could be obtained and assessed for future action. An effective monitoring system had been instituted at not great costs, since it was based on an already existing information system. This "monitoring" aspect is particularly important in drug abuse, and especially relevant for a country like Indonesia, which consists of thousands of islands scattered over a vast geographical area, and located in a very strategic area in terms of communication and drug traffic.

Periodic assessments of the drug situation would have been cheaper, but this kind of approach will miss the essential monitoring component of the regular information system.

It certainly would pay to extend this system to other hospitals and treatment centres, e. g. general hospitals, police treatment centres, and other treatment facilities not covered by the present system.

The development of an information system for outpatient clinics to partly monitor the extramural aspects of drug abuse is in process and will be effective very soon.

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ACKNOWLEDGEMENTS

I would like to extend my indebtedness to all the psychiatrists physicians, nurses social workers and other paramedical personnel in all of the 35 psychiatric facilities who have diligently completed the GPPQ forms, so that this paper has been possible.

I would also like to thank my colleagues from the Drug Dependence Institute, Fatmawati Hospital, Jakarta for their numerous suggestions which were very valuable.

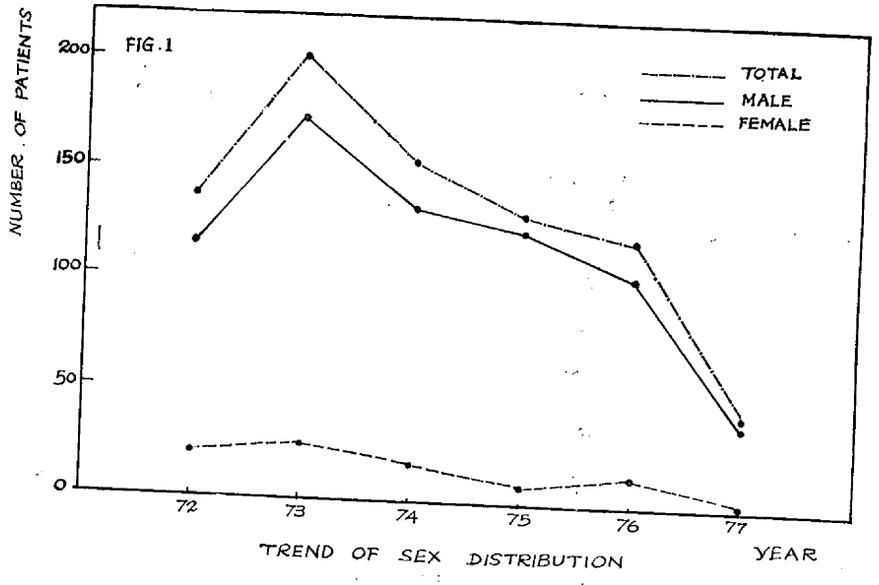
FIG. 1
NUMBER OF PATIENTS
200
150
100
50
0
TOTAL
MALE
FEMALE
72
73
74
75
76
77
YEAR
TREND OF SEX DISTRIBUTION

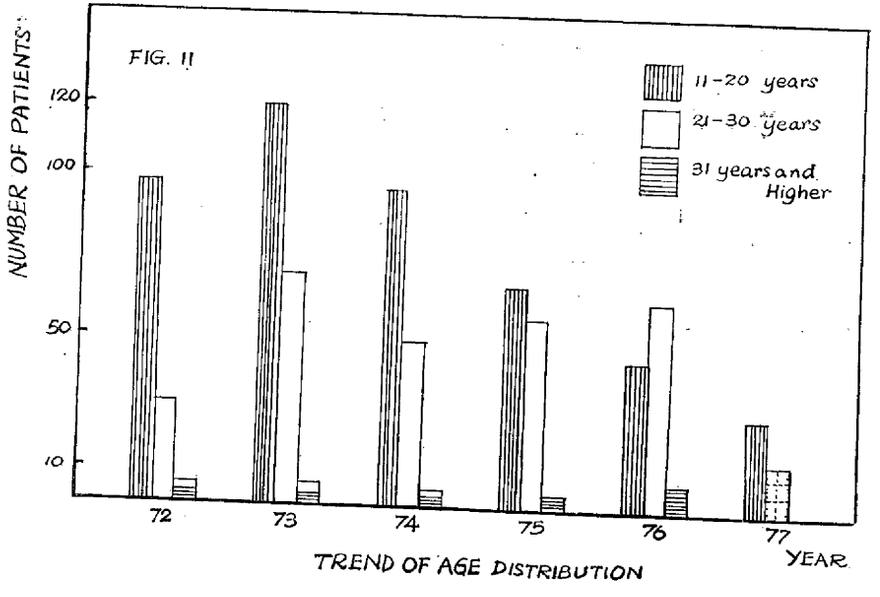
FIG. II
NUMBER OF PATIENTS
120
100
50
10
11-20 years
21-30 years
31 years and Higher
72
73
74
75
76
77
YEAR
TREND OF AGE DISTRIBUTION

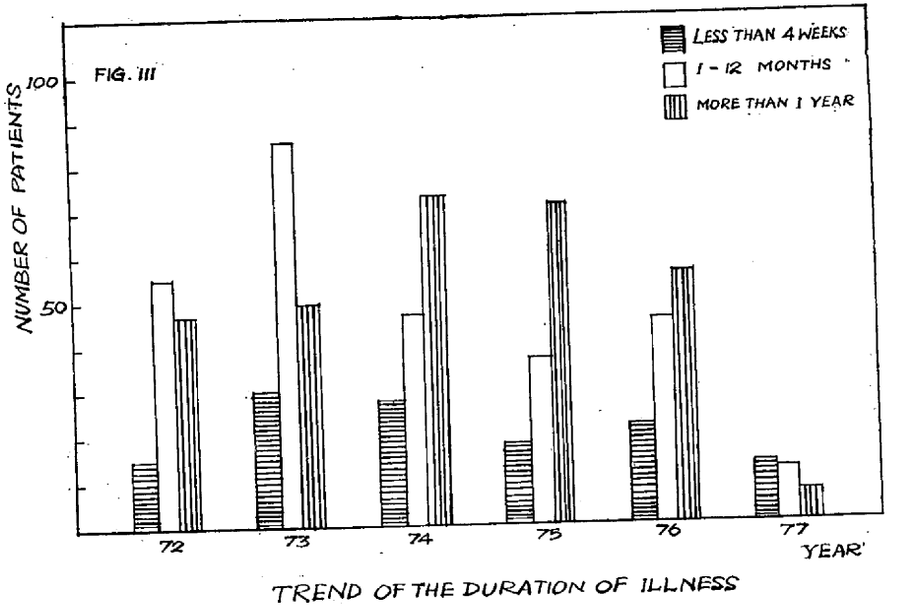
FIG. III
NUMBER OF PATIENTS
100
50
LESS THAN 4 WEEKS
1 - 12 MONTHS
MORE THAN 1 YEAR
72
73
74
75
76
77
YEAR
TREND OF THE DURATION OF ILLNESS

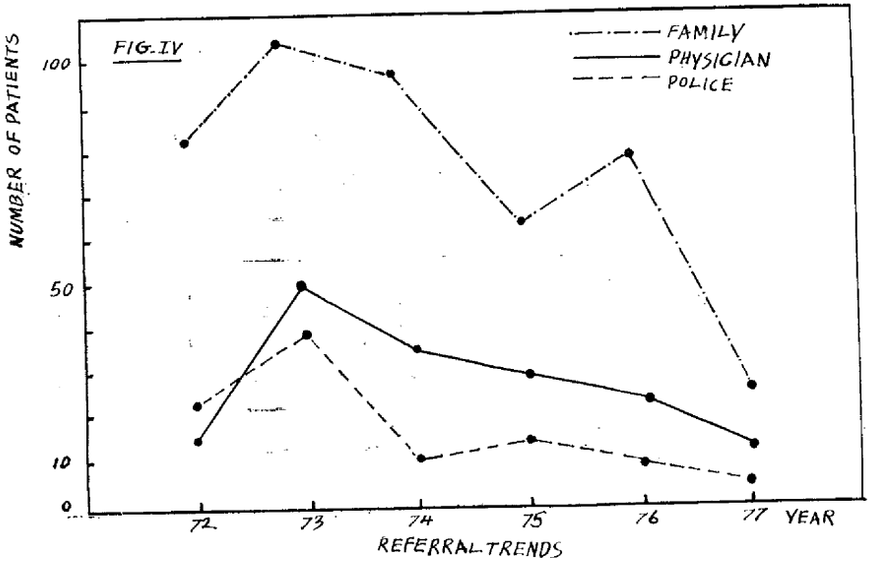
FIG. IV
NUMBER OF PATIENTS
100
50
10
0
FAMILY
PHYSICIAN
POLICE
72
73
74
75
76
77
YEAR
REFERRAL TRENDS

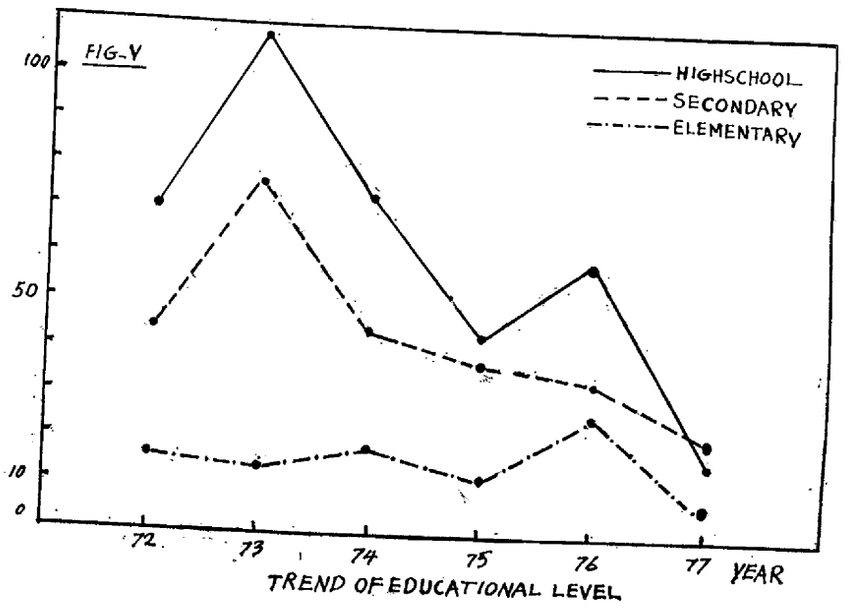

TABLE 1

SEX DISTRIBUTION (ALL ADMISSIONS)

YEAR	FEMALE	MALE	TOTAL
1972	19 (14.3)	114 (85.7)	133
1973	24 (12.1)	174 (87.9)	198
1974	16 (10.5)	136 (89.5)	152
1975	7 (5.4)	123 (94.5)	130
1976	13 (10.7)	109 (89.3)	122
1977	2 (4.8)	40 (95.2)	42
TOTAL	81	696	777

TABLE 2

AGE DISTRIBUTION (ALL ADMISSIONS)

YEAR	11-20 yrs	21-30 yrs	31-40 yrs	41-50 yrs	51-60 yrs	60 or more yrs MISC	TOTAL
1972	96 (72.2)	29 (21.8)	5 (3.7)	-	-	-	3 (2.3)	133
1973	121 (61.1)	71 (35.9)	1 (0.5)	-	1 (0.5)	-	4 (2.0)	198
1974	95 (62.5)	49 (32.2)	5 (3.3)	1 (0.7)	-	-	2 (1.3)	152
1975	66 (50.8)	56 (43.1)	2 (1.5)	1 (0.8)	-	-	5 (3.8)	130
1976	45 (36.9)	62 (50.8)	5 (4.1)	1 (0.8)	3 (2.4)	4 (3.3)	2 (1.6)	122
1977	27 (64.3)	15 (35.7)	-	-	-	-	-	42
TOTAL	450	282	18	3	4	4	16	777

TABLE 3

PLACE OF UPBRINGING (ALL ADMISSIONS)

YEAR	URBAN	RURAL	SUBURB	OTHER	TOTAL
1972	110 (82.7)	3 (2.3)	20 (15.0)	-	133
1973	165 (83.3)	3 (1.6)	26 (13.1)	4 (2.0)	198
1974	137 (90.1)	1 (0.7)	12 (7.9)	2 (1.3)	152
1975	113 (86.9)	4 (3.1)	12 (9.2)	1 (0.8)	130
1976	101 (82.8)	4 (3.3)	17 (13.9)	-	122
1977	31 (73.8)	1 (2.4)	10 (23.8)	-	42
TOTAL	657	16	97	7	777

TABLE 4

MARITAL STATUS (ALL ADMISSIONS)

YEAR	SINGLE	MARRIED	SEPA-RATED	DIVOR-CED	WID-OWED	OTHER	TOTAL
1972	97 (72.9)	22 (16.6)	-	-	-	14 (10.5)	133
1973	160 (80.8)	16 (8.1)	2 (1.0)	8 (4.0)	-	12 (6.1)	198
1974	118 (77.6)	14 (9.2)	-	3 (2.0)	-	17 (11.2)	152
1975	110 (84.6)	16 (12.3)	-	3 (2.3)	-	1 (0.8)	130
1976	88 (72.1)	26 (21.3)	2 (1.6)	3 (2.5)	1 (0.3)	2 (1.6)	122
1977	36 (85.7)	5 (11.9)	-	-	-	1 (2.4)	42
TOTAL	609	99	4	17	1	47	777

TABLE 5

PATIENT'S INCOME LEVEL (ALL ADMISSIONS)

YEAR	NONE	LOW	MEDIUM	HIGH	MISC	TOTAL
1972	3 (2.25)	15 (11.3)	106 (79.7)	3 (2.25)	6 (4.5)	133
1973	9 (4.60)	18 (9.1)	153 (77.3)	3 (1.5)	15 (7.5)	198
1974	3 (2.0)	15 (9.9)	123 (80.9)	3 (2.0)	8 (5.2)	152
1975	2 (1.5)	9 (6.9)	109 (83.9)	3 (2.3)	7 (5.4)	130
1976	1 (1.8)	13 (10.7)	34 (27.8)	8 (6.6)	66 (54.1)	122
1977	1 (2.4)	3 (7.1)	6 (14.3)	2 (4.8)	30 (71.4)	42
TOTAL	19	73	531	22	132	777

TABLE 6

DURATION OF ILLNESS (ALL ADMISSIONS)

YEAR	1 WEEK	1-4 WEEKS	1-6 MONTHS	7-12 MONTHS	1-5 YRS	5 or MORE YRS	UNKNOWN	TOTAL
1972	3 (2.3)	12 (9.0)	36 (27.0)	19 (14.4)	45 (11.8)	1 (0.7)	17 (12.8)	133
1973	11 (5.6)	19 (9.6)	65 (32.9)	20 (10.1)	48 (24.2)	1 (11.5)	34 (35.1)	198
1974	22 (14.5)	6 (3.9)	24 (15.8)	22 (4.5)	70 (46.1)	2 (1.3)	6 (3.9)	152
1975	9 (6.9)	9 (6.9)	24 (18.2)	12 (9.2)	59 (45.4)	8 (6.2)	9 (6.9)	130
1976	12 (9.8)	9 (7.4)	22 (18.0)	13 (10.7)	33 (27.0)	11 (9.0)	22 (18.1)	122
1977	2 (4.8)	10 (23.8)	9 (21.4)	2 (4.8)	6 (14.3)	-	13 (31.0)	42
TOTAL	59	65	180	88	261	23	101	777

TABLE 7

SOURCE OF REFERRAL (ALL ADMISSIONS)

YE-AR	PSYCH-IATRIST	DOC-TOR	OTHER PRO-FESS-IONS	SELF	FAMILY	FRI-END	AN-OTHER PATI-ENT	NON MILI-TARY	MILI-TARY	POLICE	MENT. HOSP.	GEN. HOSP.	OTHER	TOTAL
1972	10(7,5)	4(3,0)	-	7(5,3)	84(63,1)	-	-	-	2(1,5)	22(16,6)	4(3,0)	-	-	133
1973	33(16,7)	16(8,1)	-	1(0,5)	104(52,6)	3(1,5)	-	1(0,5)	-	36(18,1)	-	-	4(20)	198
1974	27(17,1)	8(5,3)	-	5(3,3)	100(65,8)	-	-	-	-	9(5,9)	-	-		152
1975	29(22,3)	4(3,1)	1(0,8)	12(9,2)	66(50,7)	1(0,8)	-	1(0,8)	-	14(10,7)	-	1(0,8)	3(2,0)	130
1976	16(13,1)	12(9,8)	-	4(3,3)	78(63,9)	-	1(0,8)	-	-	7(5,7)	-	1(0,8)	1(0,8)	122
1977	10(23,8)	2(4,8)	-	-	27(64,3)	1(2,4)	-	-	-	2(4,8)	-	-	3(2,5)	42
Total	125	46	1	29	459	5	1	2	2	90	4	2	11	777

TABLE 8

NOMINAL RELIGION (ALL ADMISSIONS)

YEAR	HINDU	BUDD-HIST	ATHEIST	ISLAM	CONFUC	CATHOLIC	PROTEST-TANT	CHRIST UNSP.	MISC	TOTAL
1972	1 (0.7)	8 (6,0)	-	69 (51,9)	5 (3,8)	26 (19,5)	18 (13,6)	5 (3,8)	1 (0.7)	133 (100)
1973	2 (1.0)	12 (6,0)	-	112 (56,6)	6 (3,0)	25 (12,7)	27 (11,7)	10 (5,0)	4 (2,0)	198 (100)
1974	-	14 (9,2)	1 (0,7)	78 (51.4)	4 (2,0)	18 (11,8)	24 (15,8)	9 (5,9)	4 (2,6)	152 (100)
1975	-	19 (14,6)	-	68 (52,3)	3 (2,3)	13 (10,0)	16 (12.3)	11 (8,5)	-	130 (100)
1976	-	18 (14,8)	-	55 (45,1)	6 (4,9)	16 (13,1)	16 (13,1)	10 (8,2)	1 (0,8)	122
1977	-	2 (4,8)	-	29 (6,9)	2 (4,8)	2 (4,8)	6 (14,3)	1 (2,4)	-	42 (100)
TOTAL	3	73	1	411	26	100	107	46	10	777

TABLE 9

EDUCATIONAL LEVEL IN YEARS (ALL ADMISSIONS)

YEARS	0	1	2	3	4	5	6	7	8	9	10	11	12	UNKN-OWN	TOTAL
1972	-	-	2 (1.5)	-	3 (2.3)	3 (2.3)	7 (5.3)	17(12.7)	11 (8.2)	11 (8.2)	27(20.4)	21(15.8)	20(15.0)	11	133
1973	-	-	1 (0.5)	2 (1.0)	2 (1.0)	1 (0.5)	3 (1.5)	18 (9.7)	32(16.1)	24(12.1)	35(17.7)	31(15.7)	43(21.8)	6	198
1974	-	-	2 (1.3)	1 (0.7)	1 (0.7)	7 (4.6)	6 (3.9)	5 (3.3)	25(16.5)	14 (9.2)	26(17.1)	23(15.7)	24(15.8)	18	152
1975	-	-	-	1 (0.8)	2 (1.5)	4 (3.1)	5 (3.9)	2 (1.5)	22(16.9)	17(13.1)	18(13.8)	22(16.9)	5 (3.9)	32	130
1976	4(3.3)	2 (1.6)	6 (4.9)	1 (0.8)	4 (3.3)	6 (4.9)	5 (4.1)	14(11.5)	9 (7.4)	12 (9.8)	17(13.9)	36(29.5)	6 (4.9)	-	122
1977	-	-	-	-	2 (4.8)	-	2 (4.8)	9(21.4)	3 (7.1)	9(21.4)	7(16.7)	9(21.4)	-	1	42
TOTAL	4	2	11	5	14	21	28	65	102	87	130	142	98	68	777

TABLE 10

TYPE OF DRUG USE BY HOSPITAL 1977

HOSPITAL	OPIUM & DERIVA-TIVES	ANALGE-SICS	HYPNO-TICS & SEDA-TIVES	CANNA-BIS	TOTAL	PERCENT
1. DHARMASAKTI	1	-	-	-	1	2.4
2. DHARMA-WANGSA	-	1	2	-	3	7.1
3. JAKARTA HOSP.	-	-	-	1	1	2.4
4. NAVY HOSPITAL	2	-	4	-	6	14.3
5. DRUG DEPEN-DENCE INSTI-TUTE	14	-	11	1	26	61.9
6. ONGKOMULYO	1	-	2	-	3	7.1
7. PALEMBANG HOSP. *	-	-	1	-	1	2.4
8. SAMARINDA HOSP. *	-	-	1	-	1	2.4
TOTAL	18	1	21	2	42	100.0
PERCENT	42.8	2.4	50.0	4.8	100.0	

* These hospitals are outside Jakarta

TABLE 11

RELATIONSHIP BETWEEN TYPE OF DRUG USE AND NUMBER OF ARRESTS 1977

NUMBER OF ARRESTS	OPIUM & DERIVA-TIVES	ANALGE-SICS	HYPNO-TICS & SEDA-TIVES	CANNA-BIS	TOTAL	PERCENT
NO ARRESTS	18	1	17	2	38	90.5
ONCE	-	-	3	-	3	7.1
THREE TIMES	-	-	1	-	1	2.4
TOTAL	18	1	21	2	42	100.0
PERCENT	42.8	2.4	50.0	4.8	100.0	

TABLE 12

RELATIONSHIP BETWEEN TYPE OF DRUG USE AND PROGNOSIS 1977

PROGNOSIS	OPIUM & DERIVATIVE	ANALGESICS	HYPNOTICS & SEDATIVES	CANNABIS	TOTAL	PERCENT
GOOD	2	1	1	-	4	9.5
FAIR	6	-	5	1	12	28.6
GUARDED	10	-	12	1	23	54.8
POOR	-	-	3	-	3	7.1
TOTAL	18	1	21	2	42	100.0
PERCENT	42.8	2.4	50.0	4.8	100.0	

DRUG ABUSE ASSESSMENT—RESULTS OF RECENT STUDIES IN THE PHILIPPINES

By

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I. INTRODUCTION

The Philippines is an archipelago that lies in the heart of Southeast Asia. To the south is the Republic of Indonesia, to the west is the Royal Kingdom of Thailand and the China Sea, and to the northeast is the city state of Singapore and the states of Malaysia. It has a total land area of one hundred fifteen thousand (115,000) sq. miles and a population of about forty two (42) million in 1975. Although the Philippines is not an opium growing or narcotics-producing country, the problem of drug abuse during the past few years has become apparent.

The climate in the Philippines favours the cultivation of marijuana plants. Marijuana plantations are clandestinely maintained in various parts of the country, especially, in thickly vegetated forested areas accessible only by foot and animal-drawn carts. (DDB Country Report 1973)

The early 70's witnessed a rapid increase of drug abuse mostly among young people in the Philippines. Intelligence reports at that time placed about one hundred fifty thousand (150,000) young people using heroin, morphine, demerol, mandrax, seconal, marijuana, tranquilizers and other psychotropic drugs and substances.

Fortunately, the declaration of Martial Law on September 21, 1972, brought about wide-reaching effects including a steady reduction on the use of drugs. Heroin and other opiates are no longer available in the streets. This, however, has redirected drug abuse into sedatives, tranquilizers, cough syrups, marijuana and inhalants. (Esser and Teng, 1974)

Up to now the number of young people involved in drugs in the Philippines has not been fully determined. The 1976 Annual Report of the Dangerous Drugs Board, presents data on the extent of drug abuse in the country based on the number of cases admitted to the various drug abuse rehabilitation centres during the period January 1972 to December 1976. A total of three-thousand two-hundred and two (3,202) new cases with ages ranging from 13 to 30 years was reported.

The noticeable abuse of drugs in the Philippines in recent years has created the need for improved information. In answer to this need, the Dangerous Drugs Board has embarked on a few projects and studies to establish even in a limited scale, the current trends, patterns and characteristics of drug abuse in the country.

II. NATIONAL CASE REPORTING

A. Central Case Registry

The DDB maintains a Central Case Registry which consists of data on admissions, releases and discharges of drug abuse cases in the various treatment and rehabilitation centres in the country. Demographic data and items concerning the client prior to entering treatment and rehabilitation are gathered through an Individual Admission Report. The data in the IAR is noted down during an interview of the client by the Intake Officer or Social Worker. The client also undergoes a battery of psychological tests to determine his psychological status prior to admission in the treatment and rehabilitation centre. Likewise, a psychiatric evaluation and a social case history is also undertaken.

The centres are required to submit to the DDB a monthly summarized report of admissions and discharges, Statistical Report (List of Residents in the Centre at the end of the month) and Quarterly Progress Report.

Trends presented by the Central Case Registry

1. Various rehabilitation Centres in the country recorded during the period January 1973 to December 1977, the following admissions:

Year	*Male*	*Female*	*Total*
1973	541	124	665
1974	581	47	628
1975	627	41	668
1976	639	51	690
1977	752	78	830

2. Distribution of cases according to age and sex for 1977:

Sex	*Below 15*	*16-20*	*21-25*	*26-30*	*31 and Above*	*12*
Males	54	403	228	39	12	
Females	19	5	4			

3. There is very little use of heroin or cocaine in the Philippines. The primary drugs of abuse among Filipinos in the order of frequency are cough syrups, tranquilizers and marijuana. Multiple abuse of drugs is common and the most common combination is marijuana with cough syrups, cough syrups with beer and other alcoholic drinks.

4. The pattern of drug abuse showed the following general characteristics:

   a. It is primarily a problem confined to the urban areas with Metropolitan Manila registering the highest percentage of admitted cases.

   b. It is primarily a problem of the youth mostly in the 16-20 age bracket. More males than females abuse drugs. Ratio is 10 to 1. As to educational status, most of the cases admitted come from the high school level.

   c. Regarding the birth order composition, statistics showed that the eldest child registered the most number of admissions followed closely by the second child and youngest child in that order.

   d. Reasons for drug taking were ranked as follows: curiosity to take drugs, peer group pressure, escape from personal and family problems.

   e. As to duration of drug use prior to their admission in the centres, 41% of drug abusers in the rehabilitation centres were on drugs for more than two years, while 24% were on drugs for less than a year, and the rest were on drugs for various lengths of time.

   f. 50% of the drug abusers were on voluntary submission for rehabilitation without court orders.

B. Report of Arrests, Seizures, Raids Conducted for Various Drug Offences.

Although the Philippines still enjoys the recent success in drug abuse control by making drugs and dangerous pharmaceutical products much less available for those who wish to abuse them, the trend in the past two years showed that the abuse of exempt drug preparations and over-the-counter drugs increased whenever the availability of marijuana was reduced.

For CY 1977, there were 837 arrests/raids conducted and one thousand four-hundred and fifty-four (1,454) persons were arrested for various drug offences, three-hundred and seven (307) cases were filed in court. During the same year, the court rendered decisions in 35 cases for unlawful possession and use of prohibited and regulated drugs, failure of pharmacists to keep record of sale of dangerous drugs and visit to a drug den.

The main illicit drugs of choice continue to be cannabis. The amount of heroin seizures fluctuate but remains at less than 1.5 kilograms. Opium poppy is cultivated in the Philippines in insignificant quantities for ornamental purposes while cannabis plants are illegally cultivated to create and sustain a drug market. The number of plants per cultivated lot varies from one to 5,000 plants. Marijuana cultivation totalling 117 were detected in 28 provinces and 29,098 plants were seized in 1977.

The data just presented cannot compare to the drug situation in the Philippines in 1972, when Metro Manila alone had an estimated 150,000 heroin addicts and abusers of marijuana, barbiturates and methaqualone. To date there are 12,000 * estimated drug abusers in the country.

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* Based on the WHO visibility factor, that for every one known client there are ten others at large.

III. Recent Studies on Drug Abuse and Its Various Aspects

A. Drug Abuse Assessment in the Philippines - A Pilot Project

The Dangerous Drugs Board and the United Nations Division of Narcotic Drugs undertook a study to pilot test the usefulness of a Draft Manual on Drug Abuse Assessment which is intended to facilitate collection of data on drug abuse from existing sources in a community, such as health and welfare agencies, law enforcement agencies schools.

Baguio City, Cebu City and Tondo, Metro Manila were chosen as pilot areas for this study since these places were identified to have high incidence of drug abuse in the past few years. Agencies in the community which had been identified to be working directly or indirectly with drug abusers were requested to assist, such as the Department of social Services and Development, the Department of Education and Culture through the city health centres, hospitals, clinics and law enforcement agencies such as the National Bureau of Investigation, Constabulary Anti-Narcotics Unit, Philippine Constabulary, Integrated National Police, Anti-Smuggling Action Center and the Barangays. The study started in February and ended in June 1977 covering a period of five months. Representatives of the various agencies in each pilot area were convened to a meeting and they were enlightened on the proper use of the forms. The representatives were requested to fill up the forms properly and regularly and these were collected at the end of every month. At the end of the first reporting month, another meeting was convened to thrash out difficulties encountered in the filling up of the forms. Data gathered from the three pilot areas during a period of three months was analyzed.

Major Findings

Data contained in this report are projections based on referrals from the various cooperating agencies involved in the project. These include both private and public schools, health agencies, rehabilitation centres, law enforcement agencies, welfare services, voluntary agencies and the Dangerous Drugs Board. A total of four hundred and eleven (411) referral cases (voluntary and apprehensions) from the three (3) pilot areas is broken down as follows: Baguio City - 100 cases, Cebu City - 181 cases and Tondo, Metro Manila - 130 cases. Information was gathered for assessment and analysis.

In summary, the data suggest the following generalities.:-

1. Sex appears to be a significant predictor of the regular use of drugs. Out of the 411 referral cases, 72.99% were males, 26.27% were females and .74% did not indicate their sex. More frequently, males are regular users of marijuana, rugby and cough syrups.

2. Of the referred cases, there appears to be a predominance of arrests and apprehensions. Among the drug users in this study, 53.28% were referred by law enforcement agencies. Only 46.72% were referred on a voluntary basis by the various agencies: 23.6% from schools, 11.44% from rehabilitation centres. 8.76% from welfare services and 1.95% from health agencies and .97% from DDB.

3. Drug abuse is primarily an urban problem with 91.24% of users having their usual place of residence in the city while only .73% come from the poblacion and 1.46% from the barrio.

4. As with the regular use of drugs, persons with more formal education appear to be most inclined to the abuse of drugs. To this group belong persons with 16 years and above education - 8.03%, 11 to 15 years education - 52.55% and 6 to 10 years education - 33.58%. The rest belong to the 0 - 5 years education - 8.03%.

5. The prevalence of use of both legal and illegal drugs is projected to be 44.53% of the population in the age range 16-25 the mean age was 20. The study also reveals the relative distribution of drug use in other age groups: 9.24% were in the age range 11-15 while 2.68% were in the age group of 26-30. The data did not show any regular drug user over 30 years of age, thus manifesting that physical maturity as indicated by chronological age makes persons less susceptible to drug abuse.

6. Results indicate that most regular users are polydrug users and as such an abuser would be using more than one drug through oral intake, inhalation or intravenous route depending on the drug used.

7. The incidence of regular use of drugs indicate 67.63% to be using drugs about weekly, 53.77% occasionally. More so, 20.92% were reported using drugs about monthly and only 14.84% were daily drug users.

8. With respect to the manner or mode of use, the majority prefers oral intake (94.4%) followed closely by inhalation (62.29%). Only 3.65% of the referred/arrested cases were intravenous injection.

9. Generally, approximately 95% of the cases included in this assessment have been continually using drugs in the last 12 months.

10. The data indicate that most of those persons regularly abusing marijuana are concurrent regular users of other drugs. The most frequent drug of concurrent regular use in the three pilot areas was cough syrup (corex, mercodol, trecodine). Approximately, 95% of all marijuana users concurrently use this drug. In addition, 20.92% were regular users of rugby while 15.57% and 7.78% were regular users of valium and biogesic, respectively. Indeed, all regular users are polydrug users.

Actually, there are more cases of drug abuse that this study shows. This is indicated by the fact that the great bulk of available data is based on arrest/apprehensions. Unfortunately, there is no simple relationship

that exists between the number of arrests and the number of users so much so that only a portion of the problem was presented. A number of persons who abuse drugs may never be apprehended; never referred to the agencies concerned or may never seek medical assistance. Nonetheless, the data made available through this assessment give us plausible evidence about the nature and extent of the drug problem which may serve as a basis for action.

B. A Study of Youth and the Use of Drugs in the Philippines

This study has been executed in 1976 under contract with UNESCO and was designed to gather information on the Filipino youths' prevailing knowledge and awareness of, and attitudes toward drug abuse and drug experience.

The sampling frame involved a nationwide sample of young people of both sexes in the 13 to 23 age group. A total of 3,922 young respondents from the three main geographic areas - Luzon, Visayas and Mindanao - chosen through multi-stage random sampling method, served as the subjects of the study.

A five-page self-administered survey questionnaire, written in simple English, was used to obtain the required information on the respondents; and their responses to 25 multiple choice questions and five-open ended questions that elicited their knowledge of and attitudes toward drug abuse and their personal experiences in the use of drugs.

The average time for administering each questionnaire was 15 minutes, copies of which were distributed to the subjects in schools and communities of the sample areas.

Major Findings

Results gathered from the study reveal the following major findings:

1. Perception of the Drug Abuse Problem.

   a. The high level of respondent awareness (85%) of the drug problem may be attributed to past efforts of government agencies to focus public awareness on this problem through mass media. Print and broadcast media had been the main sources of information.

   b. Respondents perceive drug abuse as a problem that affects all social strata and age groups.

   c. To a near majority of respondents, street corners are the spawning ground of drug abusers where the "barkada" or peer group converge in their idle time.

   d. Almost half of the subject view drug abuse as a multi-faceted problem that involves health, family, social, personal, law enforcement and economic concerns. So much so, if a friend or a close relative is discovered to be abusing drugs, they would seek help from a physician first; parents and guidance counsellors next.

2. Attitude Toward Drug Abuse.

   a. Majority agree that once discovered to be a drug abuser, a person should undergo immediate treatment and counselling and be reported to government authorities. They believed that professional help should be sought.

   b. Only less than 3% of the total sample admitted having taken prohibited or regulated drugs, marijuana being the first drug taken followed by hallucinogens and mandrax.

   c. Of the non-users of prohibited or regulated drugs, 1/3 frown upon the practice because of the awareness of the dangers of these drugs to body and mind.

   d. Reasons given for taking alcoholic drinks were the "barkada" or peer groups and the desire to please them, and for their own personal satisfaction or enjoyment. The great majority of the drinkers started drinking during the pubescent years between 14 to 18, with fewer respondents who took up drinking in the 19 to 22 age groups.

   e. The great majority (70%) of the respondents are non-smokers. There are actually less smokers than there are drinkers among the respondents.

C. Drug Use Among Public Secondary Students of the City of Manila.

The study was undertaken from November 1977 to January 31, 1978, specifically to determine the extent of drug abuse among public secondary students of the city of Manila and to identify the patterns, trends and characteristics of drug abuse in the area.

The basic instrument used in the study is a questionnaire developed by WHO as part of a world-wide study on drug abuse which consists of the following:

1. background information of subject
2. drug-taking behaviour
3. attitudinal scale

The questionnaires were administered by the staff of the Research, Statistics and Training Division, Dangerous Drugs Board with the assistance of the guidance councellors and school physicians of each public secondary school included in the study. This was done in the respective schools

at a place and time set by the schools' administration. Student respondents were not asked to identify themselves, but instead, code numbers were given to them.

The sampling universe covered all 27 public secondary schools in the City of Manila. The subjects in each school were picked at random to include at least 5% of the student population for each year in high school. The total number of respondents was seven-thousand and seventy-two (7,072).

Major Findings

a. Out of the 110,786 total population of public secondary high schools in Metro Manila, 7,072 were utilized as respondents which is about 6.38% of the total population.

Almost all of the respondents have tried using at least one drug in their lifetime. This implies that all 7,072 student respondents are/or have been drug users.

b. In this research study, the females have greater involvement in drug use than males because there are more girls than boys in each class. Out of 7,072 respondents, 45.45% were males and 53.56% were females. .99% does not have sex membership data.

c. Students started to try using drugs at the age of 10. The highest peak age of drug user for both male and female students is 13-16. The next age group mostly attracted to drug use is 17-18 years old. 12.70% belong to this age category.

There is a striking diminution of drug use with advancing age for both sexes.

d. First year and second year high school students ranked first in the use of drugs. 53.3% belong to this bracket.

Third year and fourth year high school students ranked second in using drugs and this comprise 41.5 % of the total population. 5.0% gave no response.

e. Results indicated that majority of drug users came from District I with 30.51% of the total population. Next is 25.83% coming from District IV, and 24.05% from District III. District II has the least involved student respondents in drug use with 19.61% of the total population.

f. Alcoholic beverages (30%) ranked first among the list of commonly abused drugs followed by tobacco (25.62%). Others include inhalants (11.57%), amphetamines/stimulants (8.64%), sedatives (6.65%), tranquilizers (6.25%), opiates (5.15%), hallucinogens (4.96%), cannabis (4.55%) and opium (3.9%). specifically, substances that were inhaled included nuvan (insecticide, alcohol, vicks inhaler, gasoline, spray, glue, rugby and paint thinner).

D. Drugs in School 1974: A Five Philippine City Study

This study describes detailed incidence, frequency of abuse of various drugs in five Philippine cities and provides cross city contrasts on the drug problem. The five Philippine cities in this study were arbitrarily chosen to represent the more urban communities in the country which include Baguio City, Greater Manila Area, Legaspi City, Iloilo City and Cebu City.

Respondents utilized in this study were high school and collegiate students, varying in number from city to city. An equal number of male and female students at each grade level (from first year high school to fourth year college level) cutting across public and private educational schools was taken. This is to ensure that these educational institutions are equally represented. The minimum sample size for the smallest city was set at 250, the largest city size sample was 1,000. A total of 2,048 respondents was gathered for this study.

A 17-page self-administering questionnaire was distributed to the respondents under the guarantee of anonymity. This questionnaire was written in the simplest possible manner within the capability of an average 12-14 year old first year high school student to understand. Likewise, it was written in English and average administration time was 37 1/2 minutes.

Major Findings

1. Marijuana is still the local petty drug of abuse. It is the most abused substance both in incidence and frequency. However, its use in Manila and Baguio has dropped to 21.5 and 20.42%, respectively.

2. Heroin and morphine had also dropped way down in rank, implying that these drugs presently reported as having been used were actually taken, not recently, but over the past years.

3. The first 10 ranked drugs taken by students in the five cities include Marijuana (15.14%), Benadryl (11.88%), Valium (8.02%), Paregoric (7.84%), Mandrax (5.86%), Mercodol (5.52%), Cement Glue (5.47%), Cosyr (5.08%), Benzedrine (4.84%) and Ethyl Chloride (4.49%).

4. One of the best indicators of the drug problem of an area or city is expressed by the proportion (percentage) of marijuana ever users.

5. From the total sample of 2,048 students, 37% or 760 are drug ever users.

6. Among high school and collegiate students, lateral progression of marijuana use as commonly observed, simultaneously or concurrently increases with vertical progression of polydrug abuse.

7. In the progression pattern of polydrug taking, 51% start off with marijuana. It is also the drug which is used with increasing frequency with polydrug abuse.

8. The long held and cherished belief that anti-drug propaganda will stop and prevent students from abusing drugs can no longer be supported. The positive correlations admit of two plausible interpretations. The first one suggests that exposure to anti-drug media in general invites curiosity and leads the youngsters to try drugs. This is called a "boomerang" effect which is counter productive and harmful. Another interpretation suggests that while anti-drug media in general does not prevent or stop drug-taking behaviour, drug takers instead develop a selective sensitization process toward any anti-drug medium. This selective sensitization process makes the drug taker more aware of any drug related statements or materials in his immediate surroundings leading him to perceive, record internally and recall such perceived materials easily.

CONCLUSION

The problem of drug abuse in the Philippines as evidenced by the number of referred cases cannot yet be considered serious. The favorable developments in drug abuse prevention and control brought about by the rigid implementation of RA 6425, otherwise known as the Dangerous Drugs Act of 1972, and the over-all improvement of social conditions in the country have changed the pattern of drug abuse.

The Dangerous Drugs Board as the national policy-making and coordinating body in the Philippines on all matters pertaining to drug abuse prevention and control has greatly maximized inter-agency cooperation and community participation in the over-all national drug abuse strategy to reduce the supply and demand for illicit drugs.

RECOMMENDATIONS

1. A critical in-depth study of strategies and goals in the over-all country's efforts to prevent and control drug abuse should be undertaken utilizing recent data on trends and patterns of drug abuse.
2. A nation-wide drug abuse assessment should be conducted to include not only referred cases but also the non-drug using population as well.
3. A cross-cultural study on the knowledge, attitude and practices of the Asian family towards drug abuse and the drug abuser would be most helpful particularly in planning drug abuse prevention and control measures.
4. A comparative study of the enacted drug laws in each Asian country will have implications in the over-all law enforcement efforts to control drug trafficking, smuggling and diversion in the region.
5. An exchange of recent researches and studies on drug abuse and its various aspects in the Asian region will foster deeper understanding of the problem and the social phenomena on which it evolves.
6. Epidemiological studies should be developed with a sensitivity to larger, social, psychological and political issues involved in each country.

NATIONAL DATA BANK ON DRUG DEPENDENCE IN MALAYSIA

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In cognisance of the increasing national concern regarding the growing problem of drug abuse in Malaysia, the Vice-Chancellor of the University of Science Malaysia after discussions with the Honorable Minister of Law and Attorney - General requested selected staff members of the University to develop a multi-disciplinary research programme. Following extensive discussions within the University and with Senior Officers of the Ministries of Health, Welfare Services, Education, Information, Law and the enforcement agencies, a proposal for a research programme was submitted.

In January 1975, the Honorable Minister of Law and Attorney - General directed that research project be developed as a national programme and undertake representative studies on the various aspects of the national drug abuse problem.

In 1977, the research project was placed directly under the Cabinet Committee on Drug Abuse Control which is chaired by the Honorable Deputy Prime Minister.

The primary objective of the research project is to examine the problem of drug dependence in Malaysia, with the view to formulating guiding policy decisions relating to the drug abuse problem. The project encompasses five broad areas of research investigations:-

(a) Epidemiological studies aimed at establishing the extent and nature of the drug and associated problems, as well as determining the socio-economic factors which relate to and influence drug dependence;

(b) To study the psychological make-up of the drug dependent person and to assess the psycho-social consequences of illicit use of drugs;

(c) To conduct evaluation studies on current drug treatment-rehabilitation programme as well as other preventive measures;

(d) To research into the chemical, biochemical and pharmacological basis of drug dependence, and

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* Presented by Dr V. Navaratnam

(e) To develop and maintain a national monitoring system on drug dependence and related problems.

Initial Studies

To assess the nature and extent of the drug dependence problem, four related studies have been conducted in some states of Malaysia. Three of these were inquires into populations of known users:-

(a) Those who have come forward voluntarily for treatment.

(b) Those who have appeared before the Court and been found guilty of drug related charges but who have not been sent to prison. The study also examined persons who during the year 1975 were convicted for criminal offences and also had previous drug offences.

(c) Those who have been imprisoned for drug related offences.

The fourth study examined the problem of drug misuse among the secondary school children in these states.

Studies are also being carried out to assess the present treatment-rehabilitation programmes with the view to identifying some of the needs in the current treatment-rehabilitation process. The identification and drawing up of new or improved measures might be necessary to increase the effectiveness of the national rehabilitation programme. It is anticipated that from this study some of the factors contributing to the success or failure of rehabilitation can be identified.

As a preliminary step towards developing a national monitoring system the project developed on experimental "STATE DRUG PROFILE MONITORING SYSTEM (SDPMS)". Under this system, identified agencies returned monthly information on drug dependents who have come to their attention. By using various computer programmes it was possible to use the system to determine a general ecological profile of the drug abuse problem within the state, as well as show broad changes in the pattern of drug abuse including possible shifts in the drug problem within the state.

The development of the SDPMS was extremely useful in that, it allowed us to iron out the problems of integrating data provided by different agencies, the problems of repeated reporting of an individual, and computer data file management. From an evolutionary point of view the development of the system was useful however cumulative (group) reporting was found to have its inherent problems. Whilst repeated reporting was prevented by Scanning the National Identity Numbers (a number which is unique for each individual), it was impossible to identify an individual's number with age, sex, race or any other variable. Thus this posed numerous problems when one began considering detailed analysis. However the authors feel that the system was adequate where a 'gross' picture was only needed.

Based on this experience the project developed an individual case-profile form which was designed for computerization. This was a major step towards developing a national register of drug dependents. This phase of the study was launched in mid 1976 in collaboration with the Ministry of Health, whereby all detection and detoxification Centres in Malaysia are linked to the system.

The system proved to be successful and in 1977 the Cabinet Committee decided to extend the system to all agencies and develop it as a fully integrated system.

Currently data is provided by the Ministry of Welfare Services, the Police, the Customs, the Narcotics Bureau, as well as the Health Ministry. It is anticipated that the Private Medical Practitoners will also be linked to the system. With the co-operation of all these agencies the system will be a fully integrated data system. Further this data system is linkable whenever necessary to the major national system being developed here at University Sains known as NIDAS (National Integrated Date System) which will allow comparisons to be undertaken with other socio-economic, development and other data within defined Geographical locations.

There is often a lot of debate in countries about the value and use of developing such as data system.

Rationale for Development of a National Integrated Drug Monitoring System

The use of monitoring systems, indices and case registers is of immediate importance for policy, and especially in the assessment of need, and the evaluation of implemented programmes. The accumulation of data over time, and assembled from a range of agencies is vital not only for research but also the policy maker as it can tell us how many individuals are in contact with existing services and enables the policy advisor to make informed and accurate suggestions. There is however active debate about whether such data can be a basis for epidemiological studies. Bewky (1966) has committed himself to the view that the number and nature of cases in contact with reporting agencies is an indication of total cases in the community and claim that changes in the former illustrate changes in the latter. On the other hand it may be argued that the very reasons why a segment of a population comes to the attention of reporting agencies guarantees that this segment is not representative of the whole. Thus, those drug users who seek professional help which include those with unusually high motivation to stop use or whose habit has reached crisis point. From our own various cross sectional studies of the Malaysian Youth population it is evident that only a cohort of the drug using minority who, as regular users are likely to come, in a few years time, to seek treatment, or be arrested and charged for drug offences and thus come within the scope of a monitoring system. The system will be unable to predict what occurs among the experimental drug user population.

Thus a national monitoring system, based on agency reporting, must be seen for what it is, and used realistically. It's overview of the situation, its ability to identify trends over time, and variations between geographical areas, are all infinitely superior to the picture obtained by more localised studies. Indeed the Malaysian research strategy involves both kinds of data collection, and the cross relating of finding from both.

In developing a National monitoring system it must be appreciated that no **single** reporting source accurately reflects the total magnitude or nature of the problem in the Country; and each agency reveals a portion of the picture - none being representative of the whole. Thus there is clearly the need to integrate the reporting and recording systems.

Hence the major concern of any national integrated monitoring system must be the study of the distribution of abuse in the population and of factors which influence that distribution ie. the epidemiology of the disease. Drug abuse perhaps more than any other social or medical topic has recently shown such rapid changes in pattern and nature that a rapidly responding data monitoring system is needed in order to keep pace with the spread of the problem.

The urgent need for a national integrated data system in Malaysia is highlighted in a paper by Kamal Salih and K. J. Ratnam (1975) who discuss the relationship between Government policy implementation and the need for feed back information on the problems being tackled. They note "A continuous monitoring of these problems is required in order to identify projects and to devise programmes. At the present moment, however this cannot be done in a manner which allows timely and critical analysis of the projects and programmes. The data required exist, to a large extent, in disparate Governmental departments, but retrieval and consolidation into a proper format would be time consuming and inefficient under present circumstances".

Not only are data scattered between different agencies, but also these agencies may not be co-ordinating their actions or may often be working at cross purposes. The aims of constructing a national integrated data system are seen as follows:-

(1) the mobilisation and rationalisation of existing procedures of collecting, storing and processing data resources in the country.

(2) the provision of a data banking system tailored to the needs of planning, monitoring, control, administration and evaluation of all activities.

Thus the above reasons formed also for the rationale for the development of the Malaysian Integrated drug monitoring system.

National Drug Abuse Data Bank — Computer System

Information regarding individual drug dependents obtained from the Police and hospital authorities are stored inside the computer as a computer file. This file is updated as new returns are obtained from the two agencies every month.

Each time the file is updated, the computer checks that a particular drug using individual is not duplicated, that is to say he is a new case and has not been reported before by any authority. From this computer data monitoring file, information, figures and statistics regarding the incidence and pattern of the drug abuse situation in Malaysia can be obtained at any time. Analysis can be done either on cases reported by the Police authorities alone, the Hospital Authorities alone or by all authorities jointly. This sort of selective processing is made possible because of the pressure of the unique code attached to each individual which enables us to make selections on each reporting authority alone or on the total reporting agencies. This centralised computer data monitoring file simplifies the time-consuming and complex function of maintaining up-to-date records of drug dependents feasible currently the data file is being enlarged to accommodate returns from other involved agencies such as The Ministry of Welfare Services and the Malaysian Private Practitioners.

Apart from the continuous monitoring file, separate computer files exist on (a) National Drug Seizures (b) Youth Surveys (c) Hospital Surveys (d) Criminal Justice Studies and (e) Treatment Evaluation studies.

Using the Geocode (Geoblock) as a limiting factor for an area it is possible to compute the total ecological picture of an area.

Monday, May 15, 1978.

DISCUSSION

The discussions following Dr Hughe's paper, describing WHO-activities in the assessment of drug dependence can be summarized as follows:

1. It was suggested that the WHO instruments to collect internationally comparable data be supplemented by additional data items to serve the specific needs of an individual country or region which may have similar drug use patterns. Particular reference was made to South East Asia where the opiates are the main drugs of abuse.

Dr Hughes[1] reports that one of the assumptions that underlies the use of core data for information gathering in any health field is that, over and above this minimum set of comparable data, individual investigators, countries or regions can add additional data items or modules to meet their special needs.

1 Dr Hughes of WHO regretted not being present at the discussions due to the changed date of the Workshop, but has subsequently answered questions raised.

While some participants questioned the need for internationally comparable data, there was general agreement on the need to collect data which would be useful for developing regional policies.

2. While participants recognise the WHO definition of drug dependence has political, medical and socio-cultural implications, they also felt an urgent need for more operational definitions which can be clearly understood in the local, national and regional setting. It was also noted that the current WHO data collecting instruments did not attempt to measure drug dependence in populations because of the practical and technical difficulties involved. Rather, there was an effort to gather information on drug use patterns, that is the drug, frequency, duration and route of use. It has been shown that reliable information can in this way be collected on the major parameters of drug use in most of the populations studied thus far.

3. One issue that was repeatedly stressed in the discussion was the need for reliable and valid instruments and methods.

4. Some participants stressed the need for drug use monitoring systems because patterns of drug use can change rapidly and can spread quickly between cultures. There is need for sensitive monitoring systems for early identification of new trends to permit rapid intervention responses within countries. Such monitoring systems may be based upon brief surveys repeated on a regular basis on the same population, or they may be case reporting systems which provide uniform data on a continuing basis.

5. One participant suggested a study be carried out to determine why the majority of young people **do not** become drug abusers.

A paper on the Hongkong Narcotics Register System was presented by MISS WU POW-MING. Whilst the report was highly appreciated by participants, discussion in depth was not possible as the first results of the system will not be ready before later this year. However, the author expressed her hope that the register system might prove to be useful to other countries in the region at a later date.

The paper of DR. RUDY SALAN from Indonesia on "National Mental Hospital Reporting Programme Some Trends in The Number And Characteristics of Drug Users In Indonesia, 1972 - 1977" was discussed along the following lines:

1. The instrument used is administered on admission of the patient in an in-patient treatment facility. It should be completed within one week after admission. Therefore, prognosis is not made after treatment but *before* or *during the process of treatment.* Usually prognosis is made by psychiatrists after a complete examination has been made which include history, physical examination, Psychiatric assessment, and invterview with relatives.

These are the variables on which the prognosis in the questionnaire is based.

Another prognosis usually is made at termination of treatment, but this is recorded in a separate instrument and is not mentioned and recorded here.

Participants repeatedly questioned the need for internationally comparable data, but stressed for data collection which would be useful for developing regional policies.

2. One of the difficulties participants encountered during the pilot study was the definition of criteria.

Here again participants stressed that whilst it is understandable that defining drug dependence has political, medical and socio-cultural implications there is an urgent need for such definition which can be understood clearly in the local (national) and regional setting.

3. A crucial issue in the discussion was the problem of reliability and validity of any instrument.

4. Some participants stressed the need for drug use monitoring system. Drugs of abuse and patterns of use change rapidly and often spread quickly around cultures. A current monitoring system permits rapid responses within countries and the anticipation of possible future development along with the appropriate responses. Such monitoring system may be very brief surveys repeated on a regular basis on the same population, or various other drug use indication which provide uniform data on a continuing basis.

5. Suggestion for a study on the question why the majority of young people do not use drugs at all was made by one of the participants. The discussion on DR. M. KILIBARDA's presentation on "Recent Activities of the United Nations in Drug Abuse Assessment" started with the comments of one participant who has collaborated in the pilot testing of the manual on drug abuse assessment for the collection of data from existing sources in the community. This participant stated that the instrument proved to be useful. However, the pilot testing had its limitations in the sense that it was difficult to get the cooperation of the different agencies. For example school authorities were not always willing to give information regarding drug abuse offences of their students since they believe that such information might be derogatory to the school's image. Another problem was that private physicians treating drug abusers and who have the obligation of keeping confidential records of their patients are not willing to disclose pertinent information.

The lack of financial aid also represented a problem. The completed pilot test proves to present useful data and the extension of the pilot project is now being considered.

Several questions were raised about this type of data collecting, in connection with the role and importance of the participation of psychiatrists in such projects.

2. The possibility to use general psychiatric reporting systems to integrate drug abuse in it was discussed. It was stated, that this could be a possibility and is now being considered. Therefore, the WHO exercise to list and design core items and reporting forms is especially relevant.

   For this problem there are two alternatives:

   (a) Completely integrate drug abuse information in time instrument now used with consequent major changes in computer programmes involved.

   (b) To make a separate appendix to the instrument with linkage of records.

   This would involve less cost in terms of changes in computer programmes.

3. Were there found any correlations with other mental illnesses, especially with alcoholism?

   No correlation studies were done in this project, but results from other research projects indicated that a high percentage (±60%) of drug abusers had some kind of emotional or mental disorder. Alcoholism is as yet not a problem in Indonesia although among the hospitalized patient using different drugs, alcohol is ingested occasionally. But these people can as yet not be classified as alcoholics.

4. Could hospital data serve as a data source for in depth-studies? Certain trends in hospital data may be used as indications for areas of more in depth research. Patients could be followed up during a period of time to see what happens after treatment. Some studies has been done with the follow-up of a cohort of 100 patients after termination of treatment in 1975.

The presentation of MRS. E. PONCE on the work carried out in the Philippines provoked several questions:

1. *Are there studies in the Philippines regarding previous heroin users?*

   A few studies have been conducted on clients undergoing rehabilitation a few of whom were on heroin and also on other drugs. A study conducted in 1975 follow-up released cases within a 3-year period and several of them were on heroin then. Results of these studies can be made available to interested parties.

2. *To what can one attribute the sudden increase of drug use in 1972?*

   (a) Intensified drug prevention education and information campaign directed to schools authorities, parents community and youth themselves, such that a number of those who were on drugs for some time were motivated to submit themselves for treatment and rehabilitation.

   (b) Coordinated and intensified law enforcement campaigns reaching out to areas with known high incidence of drug abuse. Operation "SAGIP" or operation Rescue conducted by law enforcers, arrested abusers and brought them to rehabilitation centres.

3. *How can one explain the non-availability of heroin in the Philippines?*

   The declaration of martial law in 1972 followed by the strict implementation of the dangerous Drugs Act of 1972 and the execution of one heroin manufacturer has contributed greatly to the non-availability of heroin.

4. *Is it the author opinion that if marijuana were legalized this would eventually wipe out other drugs?*

   I am positive that my country will never legalize marijuana. RA 6425 in the Dangerous Drugs Act of 1972 specifically lists marijuana as a prohibited drug and possession or use of such imposes 6 months and 1 day to six years imprisonment and a fine of £600 to £6000. It's legalization if ever, will not in any way wipe out use of other drugs. Filipino drug abusers are polydrug abusers and it is possible that they will try all kinds of drugs available to them.

5. *From where did the stigma of the abuser originate?*

   Since the time that drug abuse became evident in the country, society has looked down on the drug abusers. Experience shows that a few identified drug abusers in schools were expelled by school authorities. The preventive educational programmes done in the country today encourage parents and the community as a whole to treat the drug abuser as a victim and not as a criminal and that he should be dealt with sympathy and understanding.

6. *What has the Philippines done, particularly the Food and Drug Administration, regarding the use of librium etc.?*

   The Technical Committee of the Dangerous Drugs Board has recommended that a special listing of drugs commonly abused, be prepared such that a youth caught in possession or use of such drugs can be arrested by the law enforcers. It has also recommended that the FDA should also require drug manufacturers to get the approval of the Board before they bring out to the market any drug which potential for abuse.

7. *Is there any indicator that some drug abusers originate from genuine therapy?*

No record of such cases.

8. *Is there some presumption that heroin was replaced by alcohol use?*

Records and statistics show that some of former heroin users changed to alcohol and theranex (dextro prophoxypore) use.

9. *Will alcohol use be eventually stigmatized?*

I think not. Alcohol drinking is legally and socially accepted in the country.

LAW ENFORCEMENT ACTION, COLLECTION OF LAW ENFORCEMENT DATA AND REGISTRATION OF DRUG OFFENDERS

By

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Drug Abuse Situation in Singapore

1. The current drug problem in Singapore is largely the problems of heroin abuse. This problem came suddenly and deteriorated alarmingly. In 1972 only 4 persons were arrested on suspicion of heroin abuse. Two years later the figure had increased to 110 but it was not yet a problem. It suddenly became a problem in 1975 when 2263 suspects were arrested. In 1976 such suspects were arrested at the rate of 475 per month.

2. The drug problem in Singapore has been tackled on four fronts: legislation, enforcement, treatment and rehabilitation and preventive education.

Legislation

3. The Misuse of Drugs Act was enacted in 1973. Amongst other things the Misuse of Drugs Act provided for the establishment of a separate Central Narcotics Bureau, placing specified drugs under control and punishment for consuming, possessing and trafficking in controlled drugs. When the situation deteriorated, the Misuse of Drugs Act was amended in 1975 to provide for a mandatory death sentence for those convicted of:

(i) trafficking and importing/exporting more than 15 grams of heroin or 30 grams of morphine in pure content; and

(ii) manufacturing of heroin or morphine.

4. The Misuse of Drugs Act also empowers the Director and the Deputy Director of the Central Narcotics Bureau to order any person who is found to be an addict or his urine specimen is found to contain a controlled drug for compulsory treatment and rehabilitation at an approved institution for a period of six months.

5. The Misuse of Drugs Regulations, 1976 provides, among other things, for the Director of the Central Narcotics Bureau to order a person who has completed treatment at an approved institution to be subjected to a period of supervision as directed and during this period of supervision, the supervisee has to report for periodic urine test which is once in every five days.

6. A further amendment of the Misuse of Drugs Act which came into effect on 1 January 1978 stipulates that any person who has a previous conviction for consuming a controlled drug and who again commits such an offence while under supervision will be sentenced to a term of imprisonment of not less than three years.

Enforcement

7. The first trafficker to receive the death penalty was convicted on 13 July 1976. From then till end of 1977 another 12 were sentenced to death. However, the full impact of this penalty was probably not felt by the traffickers until the first execution was carried out on 28 April, 1978.

8. It became apparent in the later part of 1976 that unless a planned and co-ordinated effort was made to deal promptly with the situation, the problem would very quickly get out of control. It was evident that action has been taken not only to intercept the supply of drugs into Singapore and its distribution within Singapore but also to shrink demand for drugs in Singapore. Demand grows as a result of increasing dependency of the drugs by the addicts. Demand also grows when addicts bring others into the fold. So long as there is a strong demand of the drugs, there will be inducement to suppliers notwithstanding the preventive measures and deterrent penalties.

9. There was therefore an urgent need to estimate the size of the problem in a more refined way than going by the number of suspects arrested. There was also a need to find a method of monitoring the effectiveness of enforcement. A committee was formed to plan an operation which was codenamed Operation Ferret. The main aim of this operation was to rapidly check the growth in the population of heroin abusers and then to shrink this population to sustain enforcement and rehabilitation efforts. Opportunity was taken to collect from the Operation sufficient data to analyse the drug abuse situation.

Collection of Data

10 In Singapore any person who is *arrested* for suspicion of drug offences is required to provide a specimen of his *urine for testing*. The urine sample collected will be forwarded to the Department of Scientific Services for analysis. The result of such test will be known in 2 or 3 days after receiving the urine sample. The delay in obtaining the result is due to a large volume of samples to be processed by the department each day.

11. Every arrestee, after giving his urine sample, is required to sign a bond before he is released. The bond requires him to collect his urine result on the 7th day after the release. Any person who gives a positive urine sample and fails to turn up to collect his urine result after the expiry of the bond will be classified as an absconder. There is a special unit set up by the enforcement agencies to round up absconders. Once they are

caught, they could be charged in court or face the awful prospects of a longer stay in the rehabilitation centres, possibly for a maximum period of two years.

12. The collection of enforcement data starts when a suspect is arrested. The enforcement officer is required to furnish the particulars of each arrest in a prescribed form known as 'Narcotic Accused/Suspect Report' (a specimen of the form can be found at Appendix B). This form covers a wide range of information ranging from time, place, location of the arrest, nature of offence, type of drug seizure to the comprehensive personal particulars of the suspect, his criminal and drug history, and previous penal and rehabilitation experiences. This is the source document we are basing to make our analysis, study and assessment of drug scene, drug abusers, enforcement actions, and other related problems.

Registration of Drug Offenders

13. Any person who is convicted in court of a drug offence or who gives positive urine sample will be registered. For registration purpose a card will be created and to it the following particulars will be entered:

1) Name, NRIC No., address of the offender
2) Race, date of birth and sex
3) Offences and date of arrest
4) Type of drug involved
5) Sentence/treatments (with date)

Every subsequent incidence and entry regarding the same offender will be entered in this card.

14. All persons who seek treatment for drug abuse from medical practitioners are also required to be registered. Within 7 days after attending to any drug addict, the medical practitioner (private or public) is required by law to furnish to the Central Narcotics Bureau the particulars of the addict in a prescribed form. Based on the particulars furnished, CNB will then register the addict.

15. The registration cards of drug offenders are kept in steel cabinets stationed at the Central Narcotics Bureau. The cards are filled according to alphabatical order of the names of the offenders. This is to facilitate easy retrieval of the cards for screening and other operation purposes.

Monitoring the Progress of Operation Ferret

16. Three basic quantitative indicators are being used to monitor the progress of Operation Ferret and to assess the drug (narcotics) abuse situation from time to time. They are the expansion ratio, recidivistic ratio and the estimated drug population.

(a) **The Expansion Ratio**

The expansion ratio is the ratio between new and old abusers. When a suspect's urine sample is positive he is classified as an abuser. If he is already on record before the current arrest, he is classified as an old abuser. If he is not already on record he is considered as a new abuser. If the expansion ratio for a given period is high it indicates that there are still many addicts who are coming to official knowledge for the first time. In other words, contamination is high. On the contrary, if the expansion ratio is low it indicates that the abusers are mainly the same persons arrested again. It is not unreasonable to conclude from a low expansion ratio that the process of contamination is held in check.

(b) **Recidivistic Ratio**

As the name suggests, the recidivistic ratio gives an indication of recidivism. For any given period all suspects who have been arrested are checked to see whether they are on record. Those who are on record are then classified according to whether they have given a positive or negative urine sample. Those who have again given a positive urine sample are considered to have relapsed. The recidivistic ratio is defined as the percentage of those arrestees who are on record and have given a positive urine sample. A high recidivistic ratio indicates many old abusers have relapsed.

(c) **Estimated Abuser Population**

In order to monitor the progress of the operation i.e. to determine whether the number of heroin abusers is increasing or decreasing, it is necessary to know the population of abusers at regular points of time. Obviously, it is not possible to take a count of all heroin abusers in Singapore. However, by applying a random sampling method on data collected on arrestees each month, it is possible to estimate the population of abusers as at the end of the preceding month. A brief description of the methodology used is given at Appendix A.

SECTION II: MONITORING THE IMPACT OF OPERATION FERRET

Change of Drug Scene

17. Since the Operation from 1st April to the end of 1977, 7725 persons were arrested for committing various drug offences. 6647 drug addicts were ordered to undergo compulsory treatment and rehabilitation at the Drug Rehabilitation Centres. 246 traffickers and pushers were also arrested.

18. The intensive enforcement action has caused a great impact on drug scene in Singapore. The prompt action taken against traffickers/pushers by the enforcement agencies has disrupted the drug distribution net work.

Data feedback from operational indicates that the turning point in the escalation of drug abuse in Singapore has been reached. The spread of heroin abuse has been checked.

19. Before Operation Ferret drug abusers gathered freely at hawker stalls, coffee shops and streets, etc., to smoke heroin spiked cigarettes quite openly. Due to constant harrassment by the enforcement agencies they are now more discreet and many of them have retreated to privacy of their homes.

20. In view of the difficulty of obtaining heroin, many addicts are restoring to substitutes in order to relieve their discomfort of withdrawal. Many heroin addicts arrested admitted to resorting to Chinese samsu, toddy, cannabis, oral consumption of opium and Rohypnol tablets (containing flunitrazepam) as substitutes. The abuse of Rohypnol appeared to have spread rather rapidly. However, it was checked after the drug was placed under the control of the Misuse of drugs Act with effect from 27 January 1978.

21. At the same time preventive action against the smuggling of drugs into Singapore was intensified. Narcotics detector dogs are deployed at entry points and the parcel post depot to sniff out concealed drugs. Smugglers and traffickers are now more hesitant in their action because of the risk of being detected. Pushers are harassed and have to take all sorts of precautions such as retreating to the higher floors of HDB flats and stationing look-outs in adjoining blocks, selling only to known customers and changing the venue for transaction frequently.

Basic Indicators to Assess Drug Abuse Situation

22. Appended below are the data of the three basic quantitative indicators (i.e. the expansion ratio, the recidivistic ratio and the estimated drug abusers population) ascertained from the first 9 months of Operation Ferret:

	Estimated Heroin Abusers Population	*Abusers under Detention (Actual)*	*Population on the Loose*	*The Expansion Ratio*	*The Recidivistic Ratio*
31 Mar 77	12980	1384	11596	2.2 to 1	82%
30 Apr 77	12737	1822	10915	1.7 to 1	84%
31 May 77	12494	2803	9691	1.5 to 1	79%
30 June 77	12251	3422	8829	1.4 to 1	74%
31 July 77	12008	4056	7952	1.4 to 1	72%
31 Aug 77	11765	4709	7056	1.3 to 1	75%
30 Sep 77	11522	4968	6554	1.2 to 1	65%
31 Oct 77	11279	5198	6082	1.1 to 1	47%
30 Nov 77	11036	5003	6003	0.9 to 1	49%
31 Dec 77	10600	4713	5887	0.6 to 1	44%

23. These figures show that the objective of the operation has been achieved because there is a net reduction in the total number of abusers. Within a space of 9 months, instead of growing, the population declined from 12980 to 10600, representing a decrease of 18.3%. More important is the estimated number of heroin abusers who are on the loose because they are the ones who give rise to the demand for heroin. On 31 March 77 it was estimated that there were 11600 of them. By December 77 the estimated number had fallen to 5887, a drop of nearly half. This reflects a substantial decrease in the demand for heroin over the period.

24. The retail price of heroin monitored during Operation Ferret has been remarkably stable ranging between $6 - $7 per straw. Occasionally, smaller straws of lower price of $5 per straw have been encountered but these are exceptions. This means that measures arrived at reducing the supply of heroin into Singapore are as effective as measures aimed at reducing the demand. Otherwise, there would have been an increasing or decreasing price trend e.g. if the supply reduction measures have not been effective then a shrinking of demand for heroin should force the price to be much lower than $6 - $7 per straw. Similarly, if demand reduction measures have not been successful and the supply of heroin is significantly reduced the price of heroin in Singapore would then be increased.

25. The trends indicated by the expansion ratio and recidivistic ratio are also very encouraging:

(a) The expansion ratio started with 2.2 to 1 in March declined to 1.3 to 1 in August and further to 0.6 to 1 in December 77. This shows that the process of creating new addicts has subsided.

(b) The recidivistic ratio also dropped from as high as 82% in March to a record low of 44% at the end of 1977. Data feedback from arrests shows that majority of Singapore addicts are mere experimenters. This explains why with the harassment of enforcement actions and rehabilitation and treatments we could achieve so rapidly in bringing down the recidivism rate.

Profile of a Heroin Abuser

26. From 1st April to the end of 1977, the first 9 months of Operation Ferret, 7725 persons were found to have given a positive urine sample. Of this number 96% were abusing heroin with the remainder abusing morphine, opium, MX pills and cannabis. Some were abusing more than one type of drug.

27. The vast majority of the abusers were Singapore citizens and about 5.2% of the abusers were foreigners. Males accounted for 95.6% of the total. The ethnic composition of this group of abusers was as follows: Chinese 49.3%, Malay 43.7%, Indian and others 7.0%.

28. Most of these abusers were young with 90.0% below 30 years. The 20-24 years age group was the largest and related to the general population of Singapore. This age group also had the highest proportion of abusers.

29. About 58.6% of the abusers did not complete primary education and only 2.9% completed secondary education or higher. About 20.0% of them were unemployed. Among those who claimed that they are employed at the time of arrest the largest group were labourers or odd-job workers.

30. Slightly more than 52% of the abusers had a criminal record. Among these ex-convicts 61.8% had two or more convictions. The most common offences committed by them were gambling, theft, housebreaking and robbery.

Appendix A

Estimation of Heroin Abusers

The population of heroin abusers is made up of the following groups:

(1) heroin abusers currently under detention,

(2) heroin abusers already on record but are on the loose and are still active, and

(3) heroin abusers on the loose who are not even on record.

2. Of the three groups only those in (1) can be counted. Groups (2) and (3) can only be estimated.

3. As a first approximation group (2) is simply the total number of abusers on record minus those under detention. However, not all these 'old' abusers who are not under detention are still active. To estimate the number who are still active random sampling method can be used. For a given period, say, of a month all those who have been arrested and found to be on record are then separated into two groups according to whether their urine sample taken as a result of their current arrest is positive or negative. The assumption is that anyone who being on record as a heroin abuser currently gives a negative urine sample has not relapsed. Thus the number of arrestees who are on record and have given a positive urine sample is expressed as a percentage of all arrestees on record the percentage may be called the recidivistic ratio. This recidivistic ratio multiplied by the number of 'old' abusers on the loose gives the number of 'old' abusers on the loose *who are still active.*

4. Similarly random sampling can be used to estimate group (3). For any given period of, say, a month, if all those arrestees who have given a positive urine sample are checked against CNB central records it will be possible to determine how many are 'old' abusers (i.e. those who are already on record) and how many are 'new' abusers (ie those who are arrested the first time). The ratio of 'new' abusers to 'old' abusers may be called the expansion ratio. The number of 'new' abusers expressed as a percentage

of all abusers (i.e. all those who have given a positive urine sample irrespective of whether they are already on record) may be called the expansion factor.

5. Therefore the population of active heroin abusers at a specified date may be estimated as follows:

(a) Find out the number of 'old' abusers as at the specified date and minus from it the number who were under detention/, imprisonment on that day;

(b) For a period immediately following that date of say, a month find out the recidivistic ratio;

(c) Multiply the recidivistic ratio with the result obtained in (a) above. This gives the number of *active* 'old' abusers on the loose on the specified date;

(d) For the same period as in (b) above find the expansion ratio;

(e) Multiply the expansion ratio with the result obtained in (c) above to estimate the number of 'new' abusers who have yet to be arrested;

(f) Add the results of (e) and (c) to get the total estimate of abusers on the loose (both 'old' and 'new');

(g) Add to (f) all those abusers under detention/ imprisonment to get the estimate of total heroin abusers on the specified date.

6. These steps can be reduced to a simple formula:

$$(A - B)\ \frac{a+c}{a+b} + B$$

where A = all heroin abusers on CNB records at the specified date;

B= all heroin abusers under detention/imprisonment on the specified date;

a= persons arrested in a period immediately following the specified date who are on CNB records and whose urine sample is positive;

b= persons arrested in the same period who are on CNB records but whose urine sample is negative;

c= persons arrested in the same period who are not on CNB records but have given a urine sample that is positive.

FORM A
NARCOTICS ACCUSED/SUSPECT REPORT

DIV/UNIT .....
SERIAL NO .....
REPORT NO .....
NRIC No. ☐☐☐☐☐☐☐
(Passport No. for foreigner)
Occupation .....
Salary .....

Name .....Alias (if any).....
Address .....
Date of birth .....
Highest standard passed .....

1 SEX
Male ☐
Female ☐

2 NATIONALITY
Singapore Citizen ☐
Permanent Citizen ☐
Malaysian ☐
Indonesian ☐
Stateless ☐
Others (specify) ☐

3 RACE
Chinese ☐
Malay ☐
Indian ☐
Eurasian ☐
Others (specify) ☐

4 MARITAL STATUS
Single ☐
Married ☐
Separated ☐
Divorced ☐
Widowed ☐

5 N.S. STATUS
SA.F.
Full-time ☐ ☐
Part-time ☐ V.C.
Reservist ☐ ☐
Registered to be called up ☐ S.C.
Exempted from N.S. ☐ ☐
Not liable for N.S. ☐

6 ARREST
Based on information received ☐
During operation ☐
Screening of Urine ☐

7 AMOUNT OF DRUG SEIZED
Heroin .....
Morphine .....
Opium .....
Cannabis .....
NX .....
Others (specify) .....

8 PLACE OF ARREST
Public Housing Estate ☐
Non-Public Housing Estate ☐

9 LOCATION OF ARREST

a. Government Building
CNB HQ ☐
SAF Camp ☐
Police Station ☐
Prison ☐
Customs ☐
National Stadium/Swimming pool/Sports Complex ☐
School/University/College ☐
Others ☐

b. Private Residence
(for Public Housing)
1-room ☐
2-room ☐
3-room ☐
4-room ☐
5-room ☐

(for non-Public Housing)
Bungalow/Semi-detached ☐
Terrace House ☐
Private Flats ☐
Zinc-roof/Attap house ☐

c. Within premises of Public/Private Flats other than Private Residence
Corridor ☐
Staircase ☐
Lift ☐
Void deck ☐
☐

d. Commercial Premises
Hawker Centre/Stall ☐
Shopping Centre/shop ☐
Coffee house/ Restaurant ☐
Club house ☐
Hotel ☐
Nightclub/Bar/Other place of entertainment ☐
Factory/Workshop ☐
Office ☐
Others (specify) ☐

e. Other Areas
Street ☐
Car-park ☐
Public park ☐
Public toilet ☐
Construction site ☐
Vacant house ☐
Others ☐

10 **Action taken**

Released on bail ☐ Detained ☐ Referred to SAF ☐ Prosecuted ☐

On ..... at ..... at .....
(date) (time) (place)

a party comprising.....
(Identities of arresting officers)

arrested suspect.....for .....
(name) (offence)

He was alone/with a group of other suspects namely:

Name NP 339 Serial No. Section

Quantity of exhibits seized and from where.....

.....

.....

Other useful information.....

.....

.....
Signature of Investigating Officer

DIV/UNIT .....

SERIAL NO. .....

FORM B

11 **Urine test result**
- Positive ☐
- Negative (NP 338 attached) ☐

12 **Result** (Date .....)
- Released ☐
- Placed under wanted list ☐
- Sent to DRC ☐
- Referred to immigration for expulsion ☐
- Referred to Welfare Homes ☐
- Court-Martialed ☐
- Prosecuted (indicate offence and sentence) ☐
- Detained under CL ☐

13 **Secret Society Membership**
- Non-member ☐
- Member ☐
- Fighter ☐
- Organizer ☐

14 **Status of offender**
- Manufacturer ☐
- Trafficker ☐
- Pusher ☐
- Addict ☐
- Beginner (consuming-¼ or less phial of heroin daily) ☐

15 **Type of drug involved**
- Heroin ☐
- Morphine ☐
- Opium ☐
- Cannabis ☐
- Others (specify) ☐

16 First started to take drug
Month.....Year.....

17 **Offences**
- Manufacturers ☐
- Import/Export ☐
- Trafficking (death penalty) ☐
- Trafficking (20-30 years) ☐
- Trafficking (ordinary) ☐
- Possession of drug ☐
- Consuming of drug ☐
- Possession of utensils ☐
- Permiting premises to be used for administration etc of controlled drug ☐ ☐

18 **Usual place of consumption**
- Private residence ☐
- Public housing ☐
- Coffee shop/stall ☐
- Coffee house/Bar/ Restaurant/ Nightclub ☐
- Theatre ☐
- Shopping Centre/Shop houses ☐
- Opium/Gambling den ☐
- Street ☐
- Park ☐
- Public toilet ☐
- Vacant house ☐
- Corridor ☐
- Staircase ☐
- No fixed place ☐
- Others ☐

19 **Type of dwelling unit**

Public housing
- 1-room flat ☐
- 2-room flat ☐
- 3-room flat ☐
- 4-room flat ☐
- 5room flat ☐

Non-Public housing
- Bungalow/Semi-detached ☐
- Terrace ☐
- Private Flat ☐
- zinc roof/attap house ☐

20 **CRO Screening**
- Traced ☐
- Untraced ☐
- No. of previous convictions (See CRO 60 attached) ☐

FOR OFFICIAL USE ONLY

21 **Type of previous offences committed**
- Robbery ☐
- Housebreaking ☐
- Extortion ☐
- Sexual Offence ☐
- Consuming/Possession of drug ☐
- Other drug offences ☐
- Possession of offensive weapons ☐
- Causing hurt ☐
- Theft ☐
- Gambling ☐
- Others ☐

22 **Previous Rehabilitative/Penal Treatment** ☐
- DRC ☐
- Fine ☐
- Probation ☐
- Approved School Police Supervision ☐
- Young Offenders Section ☐
- Imprisonment ☐
- R. T. C. ☐
- C. L. D. ☐
- Prevention detention ☐
- Others ☐

23 **CNB Screening**
- Involved in heroin before Yes/No
- Consulted medical practitioner for treatment of drug before Yes/No
- No. of previous drug convictions ☐
- No. of admission to DRC ☐
- No. of times placed on Probation ☐
- Date of last record .....
- Type of drug last involved .....

AN INTERPRETATIVE EPIDEMIOLOGY OF DRUG DEPENDENCE IN THAILAND

By

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I. Introduction

Drug dependence in Thailand is certainly not a new facet of the modern social happening. It is more like an old acquaintance who drifted in and out of the country interest through the ages. The earliest historical document relevant to the opium dependence was a criminal law passed around the middle of the 14th century. This law contained some remarkably enlightening passages such as".....the opium addicts cannot be effectively withdraw without some enforcement measures....." and ".....the family of the convict of drug offence must guarantee under stiff fine an extended period of close surveillance after released from term of imprisonment....."

The 19th century was the turbulent period for the history of the opium problem in Thailand. Starting with the organization of a full blown illicit opium trafficking by the Chinese syndicates in the cities along the sea coast of the Gulf of Siam and culminated in a series of civil war between the syndicates and the royal army in the years 1841, 1843, 1846 and 1847.[1] To brace against the intimidating pressure of the foreign opium trade and to curb the extent of internal illicit trafficking, King Rama IV decided to legalize the opium trade and use only among the Chinese in the country in 1851[2]. A high opium trade revenue and a strong law enforcement control were concurrently imposed as preventive measures. One interesting outcome was the escalation of the opium trade revenue to the fifth priority rank among the traditional exports in the subsequent years. This sizable revenue had been the origin of repeated embarrassment for the ruling body of the following generations when complete legal ban was again reconsidered.

Under a different term of reference, cannabis, locally known as "Ganja", can be considered an indigenous drug. The fact that the plant can be easily cultivated insure the perpetual availability. The well known hallucinogenic effect has not deterred its place in the traditional cuisine. Cannabis smoking unless carried to the extreme is well tolerated by the general public with a definite attitude of amusing naivety.

* Presented by Dr. Vichai Poshyachinda

These few historical and traditional anecdotes were hopefully a sufficient framework illustrating the dorment substrata from which the current drug dependence emerged.

From 1972 through 1975, there were series of official reports and research studies on drug dependence among the students and the drug dependent patients. These reports had been comprehensively reviewed in November 1976[3]. Since the beginning of 1977 a new series of research had been completed from the collaboration between the Institute of Health Research (IHR) and the WHO/UN/Thai Drug Dependence Treatment Programme with the support of the United Nation Fund for Drug Abuse Control. These recent findings contribute a new step towards the better understanding in the epidemiology of the drug dependence which is the main substance of this communication.

The principle objective of this presentation is to convey a broad picture of the current drug dependence in Thailand. To achieve this aim and to avoid unnecessary confusion, much of the detail findings from the large surveys and virtually all the observation data were deleted although there are many instances where these became the essential supports of the somewhat definitive picture presented here. The other important points concern with the bias of the findings towards the opiates especially heroin. The extensive past experience of this country with opium and the overwhelming heroin dependence in the modern urban society had effectively damped the research interest on the other drugs. It should also be mentioned that most of the accessible materials for research study lean rather heavily towards the opiate dependence.

The material and methods of the research studies conducted by the drug dependence research programme of the IHR were summarised in Table I to demonstrate the background for the temporal and geographical projections made in the following text.

II. Epidemic pattern

The year of first use of the cannabis and the opium among the drug dependent patients (DDP) and the convicts of drug Offence (CDO) from the various studies (Table I) demonstrated the indigenous nature of the drug use pattern and the trend of the increasing incidence which started around 1967-1968 (Figures 1A&B and 4A&B). The information as revealed by the age of first drug use classified into groups of ages below 30 years and 30 years and above. the difference between the present age and the age of first drug use (Table 2) reflected the complexity of the drug user population which contributed to the picture of the incidence change already mentioned.

On December 1958, the Government passed the opium banning legislation and established the first treatment service for drug dependence. Six months immunity from the law was offered to the opium smokers to undergo treatment. The number of opium smokers registered then were 70,985[1]. In early 1959, small packages of brownish red granulated

powder were discovered on searching the person of the opium smoke admitted to the treatment service. These were proved to be heroin * in September 1959[4]. The incidence proclaimed the presence of heroin in Thailand for the first time. The statistics of the treatment center showed that most of the heroin users were the former opium smokers.

The pattern of the year of first heroin use of the current DDP at the Thanyarak Hospital and the CDO in Thanyaburi, Pathum Thani substantiated this introductory of heroin use and furthermore suggested that the rising incidence there, was only transient. The real heroin epidemic appeared to follow those of cannabis and opium with perhaps some minor chronicle delay (Figure 1.c and 5).

On comparing the temporal profile of the first heroin use incidence among DDP at the Buddhist Temple Treatment Centre, Tam Kraborg, Saraburi ** (BTTC) that were subclassed by their present residences+ into Bangkok, municipal and non-municipal areas of the other provincial cities,++ the rate increase in Bangkok was apparently lower than the other provincial cities (Figure 5).

III. Socio-economic baseline

III. 1 - Age

The age range of DDP in various treatment centers extended from the young adult to the late fifties. Some characteristic grouping could be identified. At the Thanyarak Hospital where the majority of the DDP came from Bangkok, those who were above 30 year-old tend to belong to old crowd of opium smokers in the pre-opium banned period. Nevertheless the age of opium smokers at the DTTC who mostly came from the rural areas of the provincial cities also grouped above 30 years while the heroin dependent from this population confined to the below 30 years range. The same trend was exhibited by the CDO of both sex despite of their diversed residential origin (Table No. 3).

III. 2 - Sex

There were tremendous systematic bias within the institutionalized drug dependent population studied except for the students. Even then, it was without doubt that the male predominated the scene. A definite share certainly existed among the female. The findings from the female correctional institutions of Youth and adult showed some different characteristics from the corresponding male drug dependent population,[5] e.g. marital status.

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* This type of heroin is known under various names, such as:- brown sugar, Chinese heroin, red rock and heroin No. 3. the authors.

** A provincial city 104 Km. from Bangkok towards the northeast.

\+ Covered more than 56 of the 72 cities in Thailand.

++ The classification was introduced as an arbitrary grading of urbanicity Bangkok represented the extreme of urbanization in the country, the non-municipal areas of the provincial cities represented the rural community and the municipal areas were the transition classes.

III. 3 - Marital status

The male heroin dependent studied (Table No. 1) remained single at a higher percentages than the other marital status (Table No. 4a). The incidence of being single in the male CDO of the central provinces exhibited a rising trend with the increasing age in contrary to their female counterpart (Table No. 4b). In addition the female had a definitely high incidence of cohabitation (37.1%) and separation (31.9%). These trends among the male and female CDO of the central provinces were clearly different from the statistics of the comparable group in the national census in 1976.[5]

The marital status of the opium dependent who were mostly in the middle age range showed no remarkable difference from the general population.

III. 4 - Educational status

The educational status of the drug dependence population was very complex reflecting the combination of the basic characteristics of the national education system and the inherent characteristics of the drug dependence population. The Table No. 5 presents the summary picture of the educational status.

The opium dependent showed much variation in their educational status which somewhat closely reflected the basic rural character of the population. The wide range of their age spanned over the transition period of the national education system development which added more complexity to the picture.

A fairly high education was almost an invariable status of the heroin dependent regardless of the urbanicity of their present residence. Even when the fact of the better opportunity for high education during the last decade was taken into account some group of the DDP from rural areas showed exceedingly high educational status. For example the DDP at the BTTC who had successfully completed 7 years or more in school contributed 44.2%, 57.8% and 54.8% of the groups from Bangkok, municipal and non-municipal areas of the provincial cities.[6]

This finding carried the implication that these young heroin dependents might belong to the privilege group of the rural community who could support the expense of their offsprings high education. Hypothetically, this pattern may contribute some share in the epidemic spread of heroin among the youth of the rural community.

The number of the students that appeared among the DDP and the CDO had not exceeded 13.9% - 3.8% respectively (Table No. 5). About 75% of the male CDO had their first heroin experience after the termination of their education and the mean duration was approximately 4 years after leaving school (Figure 6 A)[5]. The same picture was seen in the DDP started at the BTTC (Figure 6.B)[6].

The fraction of the DDP who started using heroin in school was 13.5% and 14.3% on the years leaving school. For cannabis, then the fraction in school was approximately 2.5 times of the heroin users.

III. 5 - Economic balance

III. 5.1 - Employment status

The employment rate of the opium smokers in general was very good. Their illegal habit and drug dependency seemed to have very little impact on their economic productivity while the heroin dependences were heavily affected (Table No. 6). The pattern yielded by the DDP at the BTTC was a good example illustrating the interrelationship between and the other demographic variables. The unemployment rate was consistently high among the below 30 year of age in all the urbanicity subclasses (approximately 38%) which represented mostly the heroin dependences while the 30 year-old and above of Bangkok showed much less degree of unemployment (approximately 19%) and only the minimal was found in the groups from the provincial cities (5.6%-6.3%, Table No. 6). It is very difficult to evaluate the employment status of the juvenile delinquent groups because of the unavailability in comparable population statistics, even then the rate of unemployment was very high.

III. 5.2. - Legitimate income

It may be rather bias to comparatively appraise the income from the illicit occupation * among the various drug dependence population. Even then, there were some drug related characteristics revealed which may be relevant to the overall picture of drug dependence.

The opium smokers whose number of cases represented the minority of the population studied gave an unusual picture of the average and the high income bracket (the mean legitimate income ranged 570.00-3,700.00 bahts/month) considering their rural origin (Table No. 7).

The range of the mean legitimate income of the heroin dependent was 1,600.00-2,500.00 bahts/month (Table No. 7) falling within the average of national income per capita for Bangkok (approximately 2,200 bahts/month). A large portion of the CDO in the central provinces resided in the slum areas or surrounding vicinity yet their income was not compatible with the general belief that slum inhabitants belong to the lower economic class. There may be a more subtle balance of economy inestimable by looking at legitimate income alone.

III. 5.3 - Money spent on drugs

The expenditure on drugs of any drug dependent individual varied tremendously. It is the daily balance which they had to decide upon by weighing out the price of the drug, the financial resource, the risk that they had to run and of course their own need of the drug.

*Job held longer than 3 months.

The price of the illicit street drugs also subject to extreme change which is unpredictable and on top of this the drug dependents had their own way in managing the price. The small broker type system for chipping off the price is perhaps universally applied by the drug user population. As an arbitrary reference, the current price of heroin No. 4 * in Bangkok at the street level is about 20.00 bahts/100 mg. In the opium cultivating area, the village opium smokers paid approximately 2.50 bahts/gm.

The mean expenditure on heroin ranged between 40.00-55.00 bahts/day and for opium 6.00-15.00 bahts/day (Table No. 8). More recent findings in juvenile delinquent for crime of drug offence revealed the mean expenditure on heroin at 37.50 bahts/day for cases in the small boys training school * *and 42.00 and 52.00 bahts/day for the boys+ and girls++ in the correctional centers respectively.

III. 5.4 - Source of extra income

Some degree of economic stress always permeated the life of the drug dependent, the source of extra income was an essential resource sustaining their delicate economic balance. The opium smokers of the remote rural areas appeared to suffer only a minor order of economic stress. Whenever pressed for additional support the majority resorted to legal means. In the group that had some young adolescent users and/or the low income incidence of family support and illegal means began to rise (Table No. 9).

The heroin dependent probably had to carry the extreme stress among the opiates dependent. Approximately 11% to 55% of the male had their parents and relatives as the source of extra income. Illegal means was in general much higher than the opium smoker. Illegal means and the drug pushing occurred in an alarmingly high rate in the female, youth (61.7%) and adult (77%) and the very young male delinquent as well (70.8%) (Table No. 9).

IV. Drug use.

IV. 1. - Type of drug used

IV. 1.1. - The opiates

The opiates that are currently used by the drug dependence population as a principle drug are heroin No. 4, heroin No. 3, opium and morphine. Codaine, although known to some opiate dependences had not yet been reported as a principle drug of abuse. Occasional morphine use admitted periodically by the adult heavy heroin users. Once in a while there were DDP who reported morphine as their principle drug. Opium is doubtless the age old indigenous illicit drug. The opium culti-

* Heroin with purity above 90%, the common street name is "white powder".

** Age range 9 - 18 years, mean 14.6 years.

+ Age range 14 - 26 years, mean 17.9 years.

++ Age range 12 - 23 years, mean 17.7 years.

vation in the mountain region of the northern provinces are also century old. In many provincial cities especially the north the availability of opium predominated heroin while in Bangkok heroin No. 4 dominate all the other opiates in availability. Analysis of opium from illicit market in the northern province yielded morphine content about 11-13%.

Heroin No. 3 as mentioned earlier was scientifically identified for first time in 1959 in Bangkok[4]. The availability in many provincial cities especially in the northern provinces at present was apparently in the type of principle drug among the CDO (Table No. 10). In Bangkok its availability at street level is probably comparable to opium in the rural areas certainly much less than heroin No.4.

The high incidence of heroin No. 4 (white powder) as the principal drug in the present report (Table No. 10) was because the existing drug dependence treatment service and the law enforcement control were focussed mainly on heroin No. 4. Periodical sampling of this drug from illicit market in the slum areas of Bangkok starting from 1976 to the present showed persistent high availability. The analysis of street samples always yielded more than 90% purity.

IV. 1.2. - **The barbiturates and the other psychoactive drugs**

In general, drugs in this class were known to the youth and the drug use population in Bangkok and the urbanized areas of the provincial cities. The majority of the rural community did not yet had the opportunity of contact. It is of interest that the middle age and the old cannabis and opiates dependent rarely expressed any preference although some of them had experimented with drugs in this area.

The secobarbital was the best known barbiturate among the drug use population. Its illicit use was generally coupled with heroin, not as a combination but as a self medication to suppress the withdrawal sign and symptom. There was no clear indication of a wide spread use as a principal drug of abuse at present. The synergistic potency with alcoholic beverage was known. More recently there were individuals who reported its use as an antidote to amphetamine among night workers such as truck drivers.

Not less than 10 types of the psychoactive drugs were used occasionally by the opiates dependent and young experimenters. The meprobamate, diazepam and nitrazepam were the 3 most commonly known. The pattern of their use were similar to the barbiturates.

IV. 1.3 - **The amphetamines**

The methamphetamine and amphetamine sulfate were both available in the illicit market in tablet and injectable forms. Their use among the professional night drivers were a common knowledge. Student with amphetamine experience were not hard to find. Nevertheless the extensive abuse of these drugs had not yet been properly investigated.

* Subjective impression of field workers who sampled street drugs and verbal reports of heroin dependent individuals.

IV. 2 - **Route of administration**

Cannabis and opium were commonly smoked in the conventional way. There were some selectivities in the method of heroin use in accordance with the type of heroin and the drug use population. "Chasing the dragon" was generally applied to heroin No. 3. Smoking in cigarette form and intramuscular and intravenous injecting were all adoped by heroin No. 4 users. Intramuscular injection was periodically reported by the heroin dependent but almost invariably in conjunction with either smoking or intravenous injecting but never the method of choice.

The young male delinquent showed preference towards smoking and gradually changed over to intravenous injection as their ages increased. The female delinquent and also the female CDO. seemed to prefer smoking in equivocal percentages to the intravenous injecting (Table No. 11). The reason for not proceeding from smoking to intravenous injecting had been given as"...afraid of the needle.....and the blood spurt in the syringe "or" going too far". A definite number of heroin smokers both young and old expressed a belief that intravenous injections could never unhook themselves from the drug.

The young adult heroin No. 4 dependent in urbanized community adopted intravenous injection at the percentages about 39%-78% (Table No. 11) The reason for their preferences were of course the intense satisfaction and economy. There was a trend of drifted over to smoking in the more rural population as shown by CDO in the provincial cities.

IV. 3. - **Dosage and frequency**

The dosage of opium and heroin No. 4 as estimated from the amount of money spent on drug and the average price in illicit market gave the approximate mean about 5 gm for opium and 250-300 mg. heroin No. 4 per day. It was not uncommon to find the heroin dependent whose daily intravenous dosage amount to 1 gm. or even more. One of the prime reasons which stabilized the dosage at the above mentioned amount seemed to be economy. The average frequency was around 2.-3 times/day for both opium and heroin. One unique pattern reported by many chronic heroin dependent was the inability to stop until all the drug on hand ran out. Hence the pattern of frequent intravenous injection with interval of 2-3 hours all through the day or until all the drug was finished tended to occur intermittently among the hard core heroin addict.

Drug dependence in Thailand

From the data already presented an interpretative picture of drug dependence in Thailand in the form of a broad sketch can be projected. Somewhere in the distant past, opium was introduced to the inhabitant of this country. Since then there were probably a certain number of opium dependence population. Their identity and characteristics were irrelevant in the present context but they must have had the evolution

of the population dynamic which assumed the pattern of periodic increase and decrease. This interspersed with stabilized incidence over the historical span of time. In the more recent past arbitrarily from 1955, onward retrospective information suggested a stabilized picture of opium dependence population dynamic. Concurrent to opium there might be other herbs with psychoactive property such as cannabis and kratom (Mitragyna) which were used in similar fashion. The use of these indigenous "drugs" might have partly overlapped with opium in term of population, so whichever drug chosen for a study would yield similar picture of a stabilized population dynamic.

The opium banned legisature was perhaps precipitating factor motivating the introduction of heroin to the opium dependent as an even better alternative. It was completely logical that immediate acceptance should happen and this was confirmed by the research findings. Why was there not a following epidemic spread? What was the controlling factor or factors? There could never be a totally satisfying answer except perhaps one wild guess that availability should be very limited then.

Almost 10 years had elapsed before the real epidemic spread started. The indigenous drugs, opium and canabis whose availability should be somewhat constant showed rising incidence of new users as well.

The initiation factor should be related to the population as in this case the availability assumed a passive role. From about 1967 - 1968 the incidence of new drug users rose gradually to the present time.

The cross sectional studies in any drug user population at the present should automatically yield fractions of various population both old and new, each carrying their own inherent characteristics. The drug use pattern would on the majority be influenced by the complexity of drug availability, the law enforcement control, the pharmacological property of the drug and the dynamic of the drug preference of the users.

In Bangkok, where the epidemic had started the earliest, the old opium user population would have been gradually displaced to a large extent by the new drug, heroin, user population. Concurrently they would also be shifted to heroin and contributed significantly to the early rapid rise of incidence. When the heroin availability reached a certain level, it would become the major factor creating the drifting pattern of the age first drug use towards the natural period of widening experience in the young if all the factors motivating man to use drugs were fully ripe in the society.

The epidemic must obviously spread through the physical route of human communication. In addition there were the social factors which urged man to travel and migrate. These would provide the opportunity of contact between the drug users and the vulnerable individuals who would logically succumb to the drug. This almost invisible infiltrative epidemic would have gone on at least for the last 5-6 years. The picture of drug dependence in the provincial areas should be the results of this ultra-complex epidemic radiating out from Bangkok.

Of the drug user population, the representative of the broad image of the old opium user group should be an adult invested with the traditional conservative character, comparatively stable and already settled in the community. In the real society setting, this image would be extensively modified by the major influencing variables of the human society such as age, sex, economy and so on. In addition, the inestimable consequences of the drug use. The probability of finding this population would have a reciprocating response relatively related to the urbanizing development.

Under the same conception, the portrait of the heroin user population would be the young adolescent, comparatively immature, invested with modern belief and conduct a rapid shifting life. The more real society image would be even more varied than the old drug user population as the influencing variables in the society should have greater impact on the individual partly because of the basic unstable character and the different type of consequences to the drug use. This recent heroin user population would naturally be found in the urbanized community.

"The final picture of the opiate user population would be the integrated varying composite of these two population."

The seemingly real population profile as revealed by the research studies will always be imperfect in terms of the total drug user population. The true value of the research result will rely on the degree of representativeness of the recruited population to the target population.

As a final remark, the authors would like to reiterate that the present communication was only a broad interpretative picture of the opiate dependence epidemiology in Thailand. It can hardly be a satisfying document because of the much deleted important details. The real extent of the drug dependence in Thailand cannot possibly be rooted in the opiates alone. Many other substances causing dependence are highly available and completely unaware of by the public. Some may have already formed the submerged base of the iceberg which will be the cause of the future national crisis. The quest for the sensitive and reliable monitoring system together with the information gathering process should be perpetually operated in harmony for the benefit of an effective pevention of the drug dependence problem.

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Source of Research Statistics

Conducted by the Institute of Health Research
Chulalongkorn University
Bangkok, Thailand.

Table No. 1

Type of Population	Date gathering				Number of Recruitment
	Location	Time	Sampling criteria	Methodology	
Drug Dependence Patient	Thanyarak Hospital Pathum Thani (Central province)	April 1975	Total sampling of allcases who could give the definite time of last heroin administration	interview & laboratory investigation	50
Drug Dependence* Patient	Thanyarak Hospital Pathum Thani (Central province)	April-May 1976	Total sampling of new admissions during 30 days	interview	500
Female Convicts* of Drug Offence	Bang Khen, Bangkok	May 1976	Total sampling	interview	263
Male Convicts* of Drug Offence	Thanyaburi Pathum Thani (Central province)	May 1976	Total sampling of inmates in region 5 and 8	interview	625
Drug Dependence** Patient	Buddhist Temple Treatment, TAM KRABROG, Saraburi (Central province)	October 1976 - 1 February 1977	Total sampling except hill tribes population	interview	1133
Convicts of** Drug Offence	Songkla (Southern province)	December 1977	Total sampling	interview	25
Male Convicts** of Drug Offence	Chiengmai - Lampang (Northern province)	February 1977	Total sampling	interview	283

Table No. 1 (contd.)

Type of Population	Data gathering				Number of Recruitment
	Location	Time	Sampling criteria	Methodology	
Javenile Delinquent ** indicated for Drug Offence & Financial Gain (*MALE & FEMALE*)	Protection & Observation Center Bangkok	February 1977	Total sampling	interview	759
Drug Dependence ** Patient (II)	Thanyarak Hospital Pathum Thani (Central province)	April 1977	Total sampling	interview	164
Student **	Lampang Teacher College Lampang (Northern province)	July 1977	Total sampling on the day of data gathering	self report questionnaires	2642
Student	Bangna Commercial College Bangkok	August 1977	Total sampling on the day of data gathering	self report questionnaires	1971
Student **	Chiengmai Teacher College Chiengmai (Northern province)	September 1977	Total sampling on the day of data gathering	self report questionnaires	2597
Student	Chandrakasem Teacher College Bangkok	November 1977	Total sampling on the day of data gathering	self report questionnaires	2038
Student	Nakhon Pathom TeacherCollege Nakhon Pathom (Central provinces)	December 1977	Total sampling on the day of data gathering	self report questionnaires	1798

(*Contd.*)

Table No. 1 (contd.)

Type of population	Data gathering				Number of Recruitment
	Location	Time	Sampling criteria	Methodology	
Drug Dependence ** (III)	Thanyarak Hospital Pathum Thani (Central province)	December 1977	Total sampling	interview	111
Student **	Chiengmai Teacher College Chiengmai (Northern province)	January 1978	50% random sampling of all students	interview	1544

* In collaboration with the WHO Research and Reporting Project on the Epidemiology of Drug Dependence.

** In collaboration with the WHO/UN/THAI Drug Dependence Treatment Programme with the support of the United Nations Fund for Drug Abuse Control (UNFDAC).

Table No. 2 **Difference between the present age and the age of the first drug use.**

Population	Difference between the present age and the age of first drug use. (years)								
	Cannabis			Opium			Heroin No. 4		
	Range	Median	Number	Range	Median	Number	Range	Median	Number
I. Drug Dependence Patient.									
I.a Thanyarak Hospital Pathum Thani (Central province)									
-Age <30	<1 - 17	4.3	214	<1 - 17	2.8	47	<1 - 11	2.2	272
-Age >30	<1 - 39	18.6	42	<2 - 47	19.1	123	<1 - 19	2.1	106
I.a Buddhist Temple Treatment Tam Krabrog, Saraburi									
I.b.1 Bangkok									
-Age <30	<1 - 18	3.5	364	<1 - 17	3.0	46	<1 - 14	1.8	343
-Age >30	<1 - 34	14.8	23	<14 - 36	21.2	23	<1 - 15	2.9	47
I.b.2 Other cities.									
-Municipality									
-Age <30	<1 - 14	3.6	131	<1 - 10	2.7	30	<1 - 7	1.5	94
-Age >30	<1 - 27	-	8	<1 - 21	5.8	37	<1 - 15	-	6
-Non-Municipality									
-Age <30	1 - 15	3.5	104	<1 - 8	2.0	34	<1 - 9	1.7	73
-Age >30	2 - 36	16.0	24	<1 - 36	9.6	115	<1 - 6	1.9	15
II. Convicts of Drug Offences									
II.a Thanyaburi Pathum Thani *(MALE)* (Central province)									
-Age <30	<1 - 19	5.0	372	<1 - 12	3.3	68	<1 - 13	2.2	435
-Age >30	<1 - 39	16.5	63	<1 - 46	18.7	65	<1 - 21	2.5	121

(Contd.)

Table No. 2 (Contd.)

Population	Cannabis			Opium			Heroin No. 4		
	Range	Median	Number	Range	Median	Number	Range	Median	Number
II.b. Bang Khen, Bangkok *(FEMALE)*									
-Age <30	<1 - 14	6.1	57	2 - 13	4.0	12	<1 - 13	3.6	86
-Age >30	<1 - 24	-	5	<1 - 25	-	11	<1 - 23	-	24
II.c. Chiengmai-Lampang *(MALE)* (Northern province)									
-Age <30	1 - 14	5.9	119	<1 - 16	3.7	53	<1 - 17	2.3	109
-Age >30	1 - 30	14.0	24	<1 - 30	15.8	95	<1 - 27	-	19
-Age <30 *							<1 - 15*	3.2	130
-Age >30							<1 - 30	8.5	142

* Heroin No. 3

Table No. 3 **Age**

Population	Age Range (years)	Mean age (years)	Number
I. **Drug Dependence Patient**			
I.a. Thanyarak Hospital, Pathum Thani (Central province)	15 - 67	30.9	483
I.b. Buddhist Temple Treatment, Tam Krabrog Saraburi (Central province)			
I.b.1 Bangkok	9 - 55	23.2	514
I.b.2 Other cities.			
Municipality			
- Opium user	18 - 60	40.1	49
- Heroin No. 4 user	15 - 38	21.8	146
Non-municipality			
- Opium user	18 - 60	41.2	127
- Heroin No. 4 user	16 - 51	23.2	117
II. **Convicts of drug Offence.**			
II.a. Thanyaburi, Pathum Thani. (*MALE*) (Central province)	18 - 60	26.3	586
II.b. Bang Khen, Bangkok (*FEMALE*)	18 - 60	26.9	117
II.c. Chiengmai-Lampang (Northern province)			
- Opium user	18 - 64	37.6	53
- Heroin No. 3 user	19 - 72	35.4	220
- Heroin No. 4 user	18 - 48	24.4	110
II.d. Songkla (Southern province)	17 - 60	26.9	25
III. **Juvenile case from Protection & Observation Centres.** (Central province)			
III.a Remand Home	12 - 18	17.8	65
III.b. Small Boys Training School	9 - 18	14.6	24
III.c. Boys Training School	14 - 22	17.9	239
III.d. Girls Training School	12 - 22	17.6	61

The incidence of being single of the heroin dependent.
A. Various population

Table No. 4

Population	Single %	Number
A.I. **Drug Dependence Patient.**		
I.a. Thanyarak hospital, Pathum Thani (Central province)	59.8	500
I.b. Buddhist Temple Treatment, Tam Krabrog, Saraburi. (Central province)	67.3	535
I.b.1. Bangkok		
I.b.2. Other cities		
Municipality	18.6	43
- Opium user	77.5	142
- Heroin No. 4 user		
Non-municipality	11.5	113
- Opium user	71.3	108
- Heroin No. 4 user		
A.II. **Convicts of Drug Offence.**	71.6	585
II.a. Thanyaburi, Pathum Thani. (*MALE*) (Central province)	19.0	116
II.b. Bang Khen, Bangkok. (*FEMALE*)		
II.c. Chiengmai. (*MALE*) (Northern province)	38.5	39
- Opium user	52.8	172
- Heroin No. 3 user	84.9	53
- Heroin No. 4 user	68.0	25
II.d. Songkla (Southern province)		

B. Changes of marital status in response to age and sex

Table No. 4 *(Contd.)*

Population	Age at recruitment (years)			
	18 - 19 %	20 - 24 %	25 - 29 %	> 30 %
B.II. **Convicts of drug Offence.**				
II.a. Thanyaburi, Pathum Thani. *(MALE)* (Central province)	91.4	58.7	69.5	29.0
II.b. Bang Khen, Bangkok. *(FEMALE)*	30.0	28.3	-	7.1
II.c. **National statistics of comparable group.**				
Male	97.1	81.9	45.7	10.4
Female	90.3	63.3	33.7	9.1

Educational Status

Table No. 5

Population	School year successfully completed				Population Number
	None %	1 - 4 %	> 4 %	Ratio 1 - 4 : >4	
I. **Drug Dependence Patient.**					
I.a. Thanyarak Hospital, Pathum Thani (Central province)	8.7	29.4	61.9	0.5 : 1	483
I.b. Buddhist Temple Treatment TAM KRABROG, Saraburi					
I.b.1. Bangkok	3.0	31.5	65.5	0.5 : 1	499
I.b.2. Other cities					
Municipality					
- Opium user	9.5	69.0	21.4	3.2 : 1	42
- Heroin No. 4 user	0.7	26.8	72.5	0.4 : 1	142
Non-municipality					
- Opium user	13.4	75.0	11.6	6.5 : 1	112
- Heroin No. 4 user	-	37.0	63.0	0.6 : 1	108
II. **Convicts of Drug Offence.**					
II.a. Thanyaburi, Pathum Thani *(MALE)* (Central province)	4.4	41.3	54.3	0.8 : 1	586
II.b. Bang Khen, Bangkok *(FEMALE)*	26.5	52.1	21.5	2.4 : 1	117
II.c. Chiengmai-Lampang (Northern province)					
- Opium user	37.3	49.0	13.8	3.6 : 1	51
- Heroin No. 3 user	8.1	52.5	39.4	1.3 : 1	198
- Heroin No. 4 user	7.1	36.4	56.6	0.7 : 1	99
II.d. Songkla (Southern province)	4.0	44.0	52.0	0.8 : 1	25
III. **Juvenile case from Protection & Observation Centres.**					
III.a. Remand Home	5.9	39.2	54.9	0.7 : 1	51
III.b. Small Boys Training School	29.2	58.3	12.5	4.7 : 1	324
III.c. Boys Training School	8.5	43.3	83.3	0.9 : 1	201
III.d. Girls Training School	18.7	54.7	26.4	2.1 : 1	53

Employment Status

Table No. 6

Population	Age < 30 Years				Age > 30 Years			
	Student %	Unemployed %	Employed %	Number	Student %	Unemployed %	Employed %	Number
Drug Dependence Patient.								
I.a. Thanyarak Hospital Pathum Thani (Central province)	8.2	21.9	69.9	291	0	10.9	89.1	192
I.b. Buddhist Temple Treatment, Tam Krabrog Saraburi								
I.b.1. Bangkok	10.4	41.1	48.5	472	0	18.8	81.2	64
I.b.2. Other cities								
Municipality	13.9	38.2	48.0	173	0	5.6	94.4	54
Non-municipality	7.3	34.7	58.0	150	0	6.3	93.7	143
II. Convicts of Drug Offence								
II.a. Thanyaburi, Pathum Thani (*MALE*) (Central province)	3.8	26.7	69.5	479	0	7.6	92.4	144
II.b. Bang Khen, Bangkok (*FEMALE*)	-	61.8	38.2	89	0	25.0	75.0	28
II.c. Chiengmai (Northern province)								
- Opium user	-	6.3	93.7	16	0	-	100.0	35
- Heroin No. 3 user	-	28.6	71.4	83	0	8.8	91.2	132
- Heroin No. 4 user	2.1	48.4	49.5	95	0	36.7	64.3	14
II.d. Songkla (Southern province)	-	9.1	90.9	11	0	15.4	84.6	13

The legitimate income of the drug dependent who had licit occupation

Table No. 7

Population	Mean legitimate income Baht/Month	Number
I. Drug Dependence Patient.		
I.a. Thanyarak Hospital, Pathum Thani, (Central province) (Heroin No. 4 user 76.8%)	2030	295
I.b. Buddhist Temple Treatment, Tam Krabrog, Saraburi		
I.b.1. Bangkok. (Heroin No. 4 user 90.6%)	2250	227
I.b.2. Other cities		
Municipality		
- Opium user	3270	13
- Heroin No. 4 user	2130	52
Non-municipality		
- Opium user	3690	21
- Heroin No. 4 user	2740	41
II. Convicts of Drug Offence		
II.a. Thanyaburi, Pathum Thani. (*MALE*) (Central province) (Heroin No. 4 user 96.2%)	1630	341
II.b. Bang Khen, Bangkok (*FEMALE*) (Heroin No. 4 user 95.4%)	1660	50
II.c. Chiengmai-Lampang (Northern province)		
- Opium user	570	21
- Heroin No. 3 user	1350	148
- Heroin No. 4 user	1690	59
II.d. Songkla (Southern province) (Heroin No. 4 user 72.0%)	1610	18
III. Juvenile case from Protection & Observation Centres (Central province)		
III.a. Remand Home (Heroin No. 4 user 98.3%)	840	38
III.b. Small Boys Training School (Heroin No. 4 user 82.4%)	620	8
III.c. Boys Training School (Heroin No. 4 user 95.2%)	930	116
III.d. Girls Training School. (Heroin No. 4 user 98.0%)	1070	22

Table No. 8

Money spent on drug

Population	Money spent on drug		Number
	Range * Bahts/day	Mean * Bahts/day	
I. Drug Dependence Patient.			
I.a. Thanyarak Hospital, Pathum Thani. (Central province)	<10 - 240	55.4	499
I.b. Buddhist Temple Treatment. Tam Krabrog. Saraburi			
I.b.1. Bangkok	10 - 300	57.1	490
I.b.2. Other cities.			
Municipality			
- Opium user	1 - 80	15.1	43
- Heroin No. 4 user	<10 - >300	56.1	137
Non-municipality			
- Opium user	1 - 100	15.9	113
- Heroin No. 4 user	1 - 220	50.6	104
II. Convicts of drug Offence.			
II.a. Thanyaburi, Pathum Thani *(MALE)* (Central province)	<10 - 400	55.0	586
II.b. Bang Khen, Bangkok. *(FEMALE)*	<10 - 300	85.0	92
II.c. Chiengmai-Lampang (Northern province)			
- Opium user	< 2 - 30	6.2	51
- Heroin No. 3 user	<10 - 100	20.7	207
- Heroin No. 4 user	<10 - 240	45.9	100
II.d. Songkla (Southern province)	<10 - 300	48.2	25
III. Juvenile case from Protection & Observation Centres.			
III.a. Remand Home*	<10 - 80	20.7	61
III.b. Small Boys Training School*	<10 - 80	37.5	20
III.c. Boys Training School*	<10 - 200	42.1	218
III.d. Girls Training School*	<10 - 150	52.2	52

* The small group of the drug dependent who used drug without having to pay for its cost were not included, for example The user-broker type and drug pushers.

Table No. 9

Source of Extra Income

Population	None	Parents & Relatives %	Legal Means %	Illegal Means %	Drug Pushing %	Number
I. Drug Dependence Patient.						
I.a. Thanyarak Hospital Pathum Thani, Saraburi (Central province)	23.6	55.5	12.8	8.1	-	483
I.b. Buddhist Temple Treatment Tam Krabrog, Saraburi						
I.b.1. Bangkok.	23.9	25.6	15.0	29.0	6.5	493
I.b.2. Other cities						
Municipality						
- Opium user	55.8	9.3	32.6	2.3	-	43
- Heroin No. 4 user	22.5	27.5	10.8	32.6	6.5	107
Non-municipality						
- Opium user	42.8	8.1	47.3	1.8	-	112
- Heroin No. 4 user	23.1	28.8	16.4	28.8	2.9	104
II. Convicts of Drug Offence.						
II.a. Thanyaburi, Pathum Thani (*MALE*) (Central province)	25.0	10.7	20.5	29.6	14.2	625
II.b. Bang Khen, Bangkok (*FEMALE*)	16.8	1.9	3.7	48.6	29.0	107
II.c. Chiengmai-Lampang (Northern province)						
- Opium user	52.8	7.5	37.7	1.9	-	53
- Heroin No. 3 user	49.1	10.4	24.5	12.3	3.6	220
- Heroin No. 4 user	30.0	23.6	13.6	20.0	12.7	110
II.d. Songkla (Southern province)	48.0	16.0	20.0	8.0	8.0	25
III. Juvenile case from Protection & Observation Centres						
III.a. Remand Home	43.1	20.0	9.2	16.9	10.8	65
III.b. Small Boys Training School	12.5	12.5	4.2	8.3	62.5	24
III.c. Boys Training School	12.5	19.4	6.0	37.9	24.1	232
III.d. Girls Training School	16.7	13.3	8.3	8.4	53.3	60

Type of drug used during the last 30 days before admission or arrest

Table No. 10

Population	Opium %	Heroin No. 3 %	Heroin No. 4 %	Others * %	Number
I. Drug Dependence Patient.					
I.a. Thanyarak Hospital, Pathum Thani (Central province)	5.0	10.4	76.8	6.7	483
I.b. Buddhist Temple Treatment Tam Krabrog, Saraburi					
I.b.1. Bangkok	0.2	0.4	90.6	8.8	534
I.b.2. Other cities.					
Municipality	19.5	10.4	61.5	8.6	221
Non-municipality	39.4	10.4	35.9	14.3	287
II. Convicts of Drug Offence.					
II.a. Thanyaburi, Pathum Thani (*MALE*) (Central province)	-	-	95.4	4.6	586
II.b. Bang Khen, Bangkok. (*FEMALE*)	-	-	94.9	5.1	117
II.c. Chiengmai-Lampang (Northern province)	13.4	55.7	27.8	3.0	395
II.d. Songkla (Southern province)	-	24.0	72.0	4.0	25
III. Juvenile case from Protection & Observation Centres. (Central province)					
III.a. Remand Home	-	-	98.3	1.7	59
III.b. Small Boys Training School	-	-	82.4	7.6	17
III.c. Boys Training School	-	-	95.2	4.8	227
III.d. Girls Training School	-	-	98.0	2.0	54

* Barbiturates, amphetamines, tranquillizers, morphine and cannabis.

Route of administration of Heroin No. 4.

Table No. 11

Population	Smoke %	Intramascular Injection %	Intravenous Injection %	Number
I. Drug Dependence Patient.				
I.a. Thanyarak Hospital, Pathum Thani (Central province)	21.6	0.9	77.5	431
I.b. Buddhist Temple Treatment, Tam Krabrog Saraburi (Central province)	27.9			
I.b.1. Bangkok	27.9	1.0	71.1	519
I.b.2. Other cities				
Municipality	41.4	-	58.6	157
Non-municipality	38.0	0.7	61.2	134
II. Convicts of drug Offence.				
II.a. Thanyaburi, Pathum Thani. (*MALE*) (Central province)	33.1	0.4	66.5	559
II.b. Bang Khen, Bangkok (*FEMALE*)	47.7	1.8	50.4	111
II.c. Chiengmai-Lampang (Northern province)	51.7	-	48.3	118
II.d. Songkla (Southern province)	50.0	11.1	38.9	18
III. Juvenile case from Protection & Observation Centres (Central province)				
III.a. Remand Home	50.9	-	49.1	55
III.b. Small Boys Training School	50.0	-	50.0	14
III.c. Boys Training School	34.1	0.9	65.0	217
III.d. Girls Training School	34.7	-	65.3	49

FIGURE I.A An Interpretative Epidemiology of Drug Dependence in Thailand

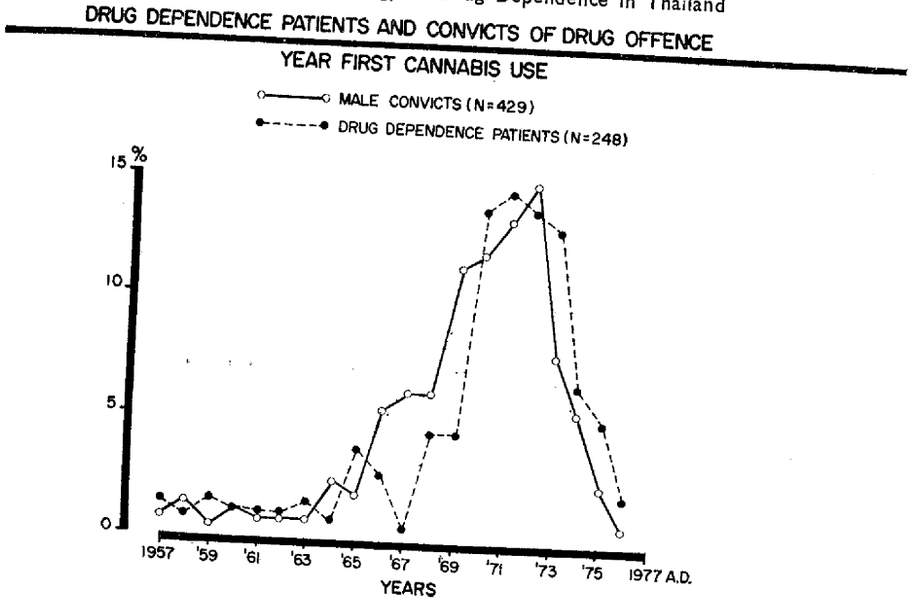


FIGURE I.B An Interpretative Epidemiology of Drug Dependence in Thailand

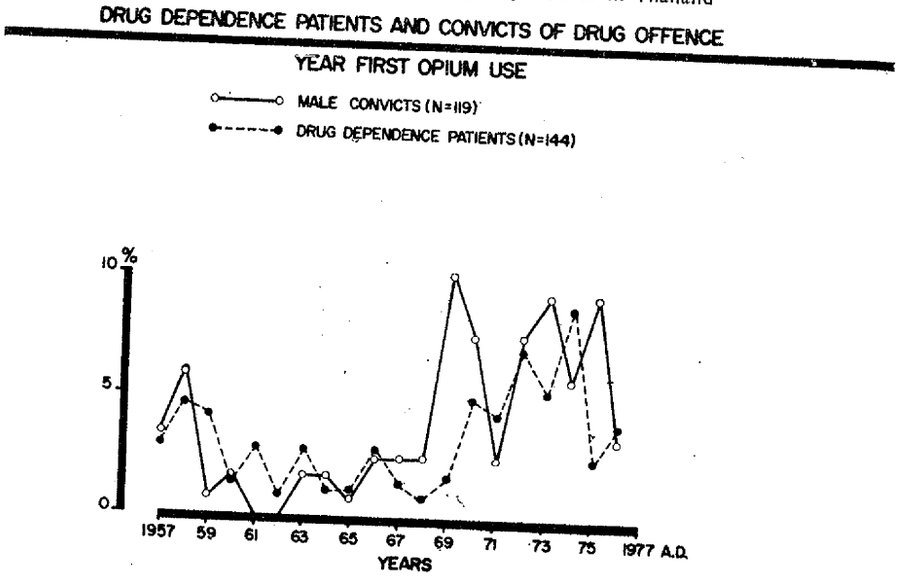


FIGURE I.C

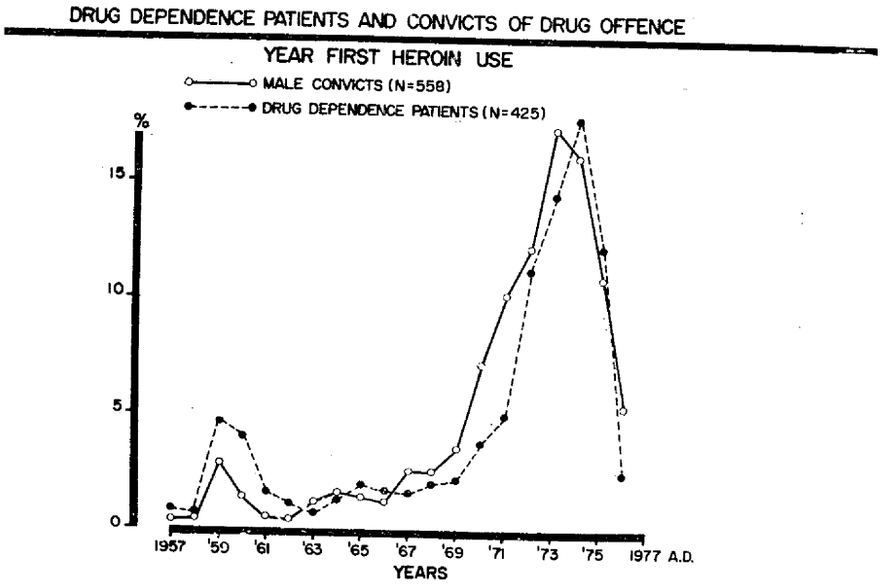


FIGURE 2.A The age of first opium use in the drug dependence patients (Thanyarak)

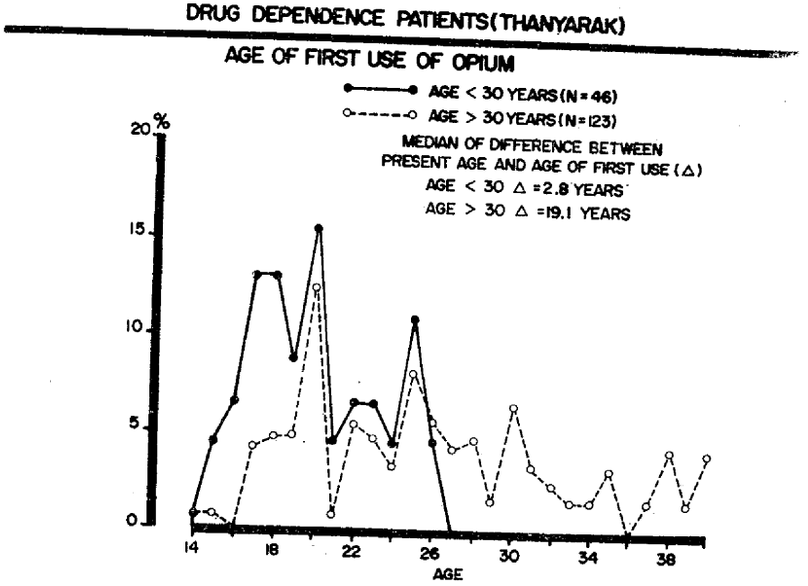


FIGURE 2.B The age of first heroin use in the drug dependence patients (Thanyarak)

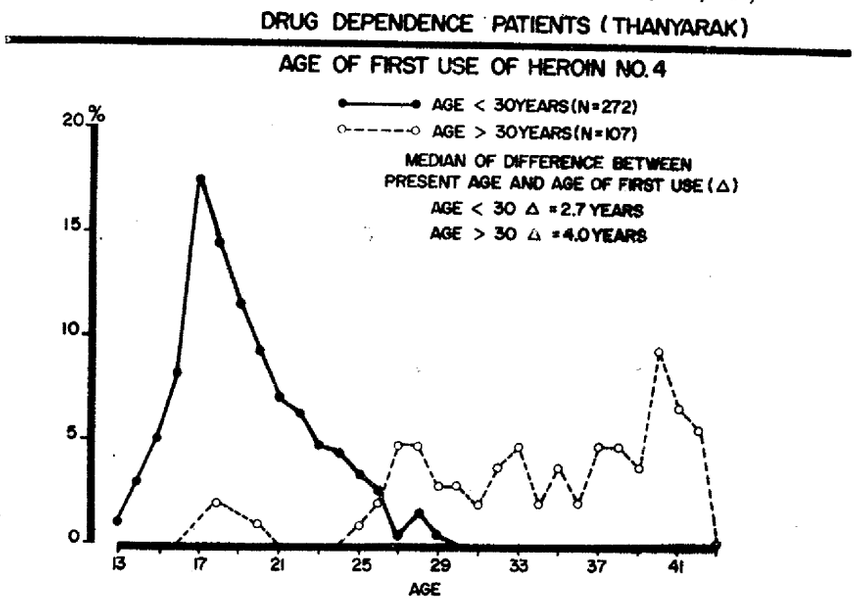


FIGURE 3 The age of first drug use in convicts of drug offences, Thanyaburi, Pathum Thani

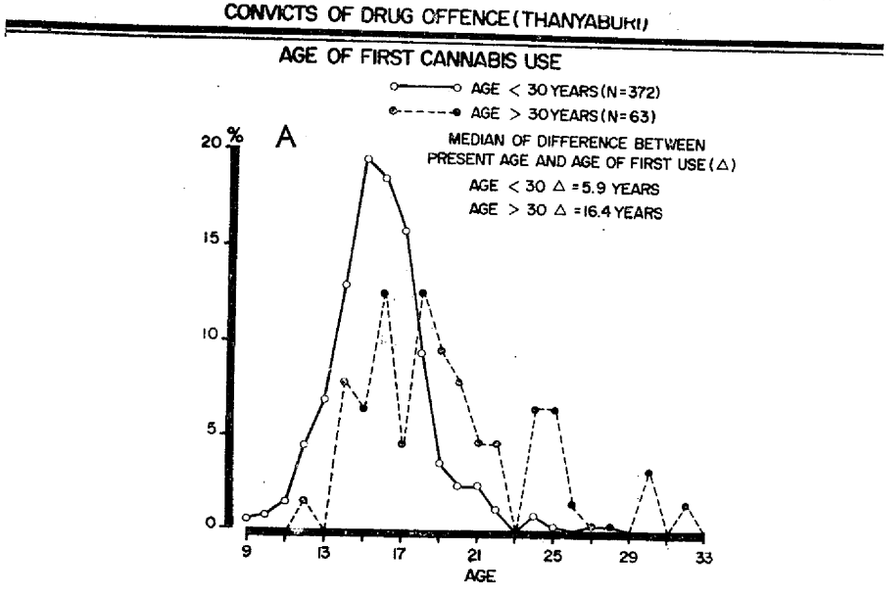


FIGURE 3

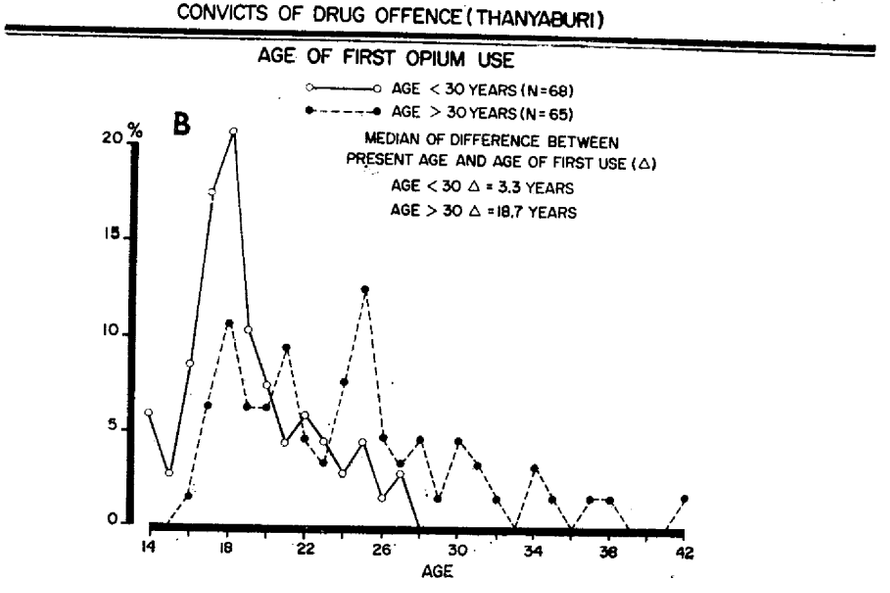


FIGURE 3

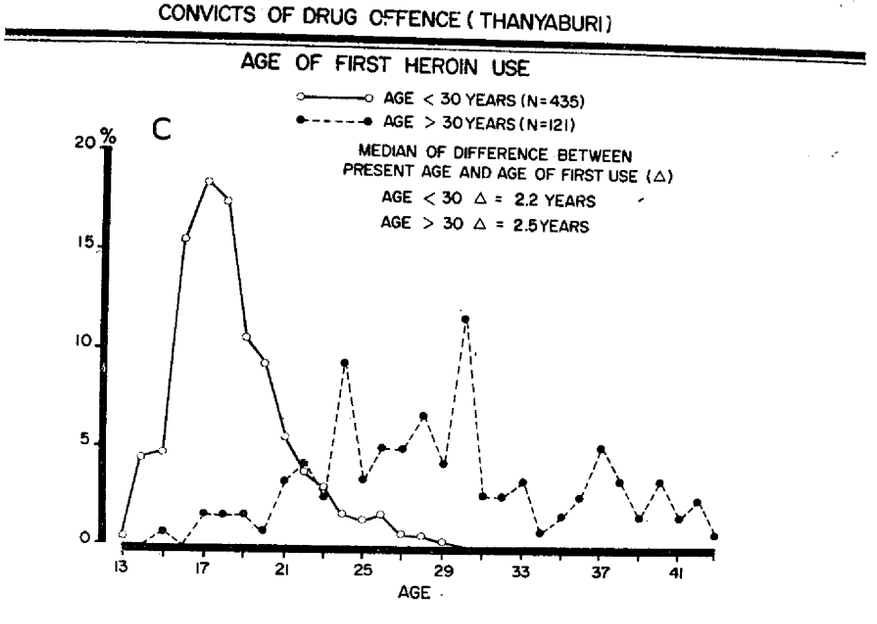
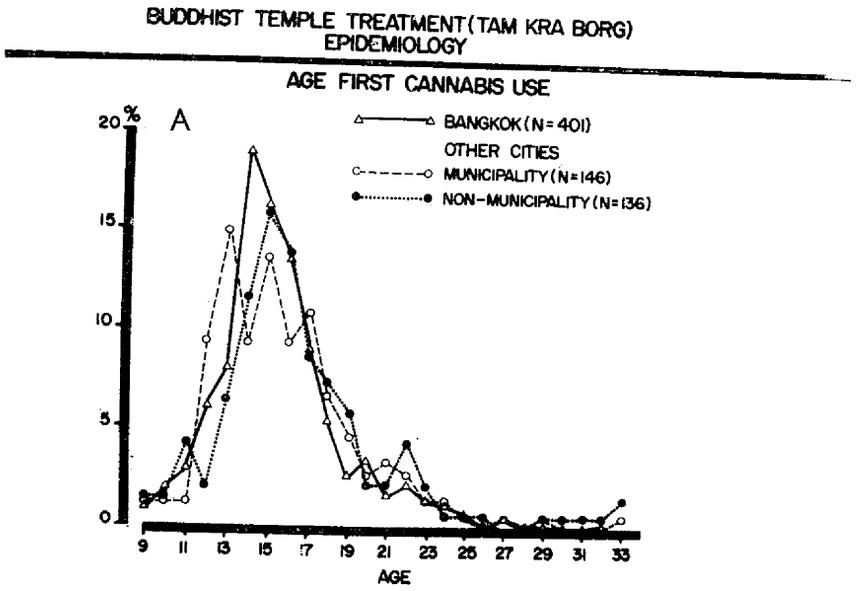


FIGURE 4 The age and year of first drug use of drug dependence patients, Buddhist Temple Treatment Centre, Tam Kraborg Saraburi



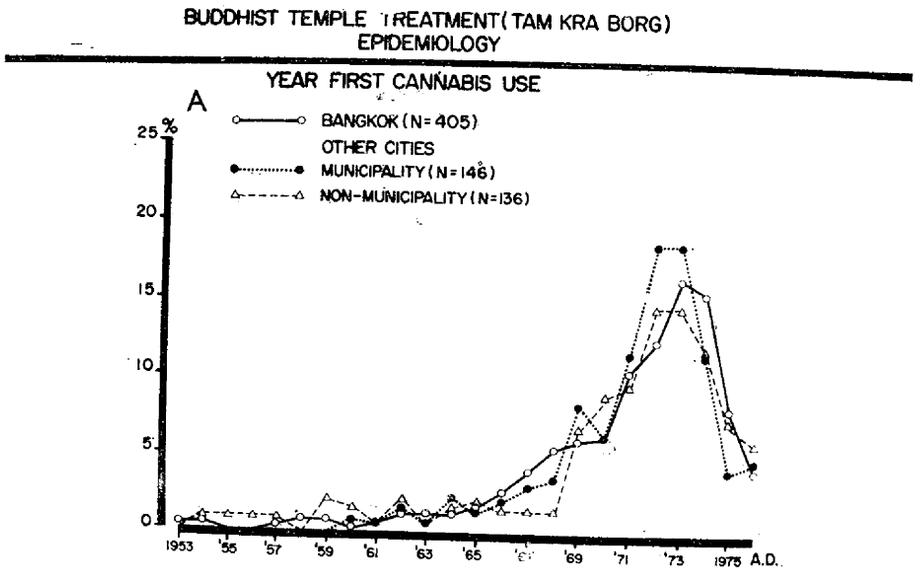


FIGURE 4.B

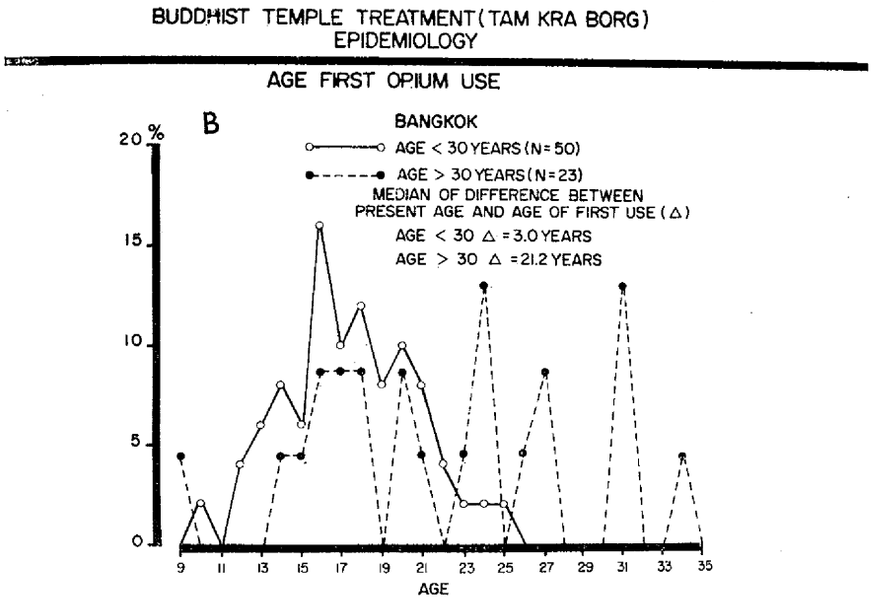


FIGURE 4.B

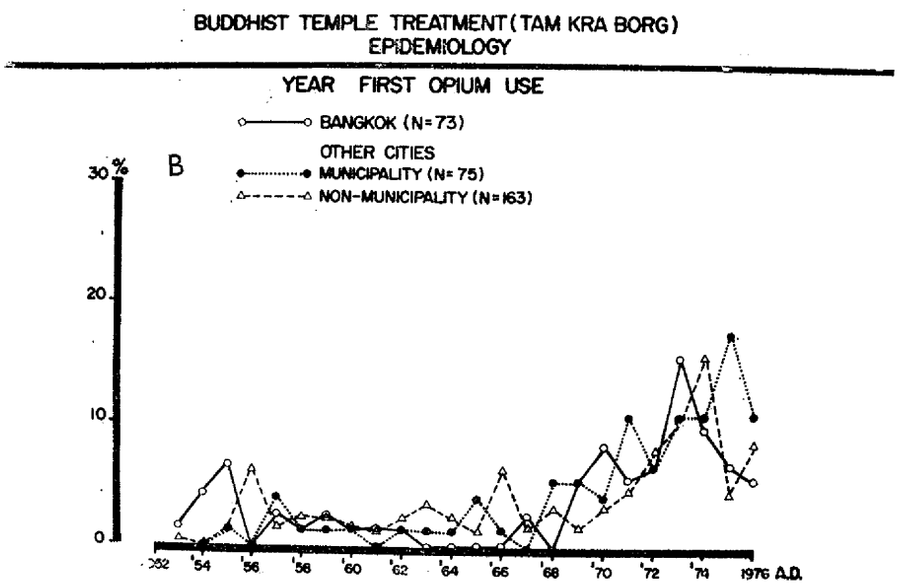


FIGURE 4.B

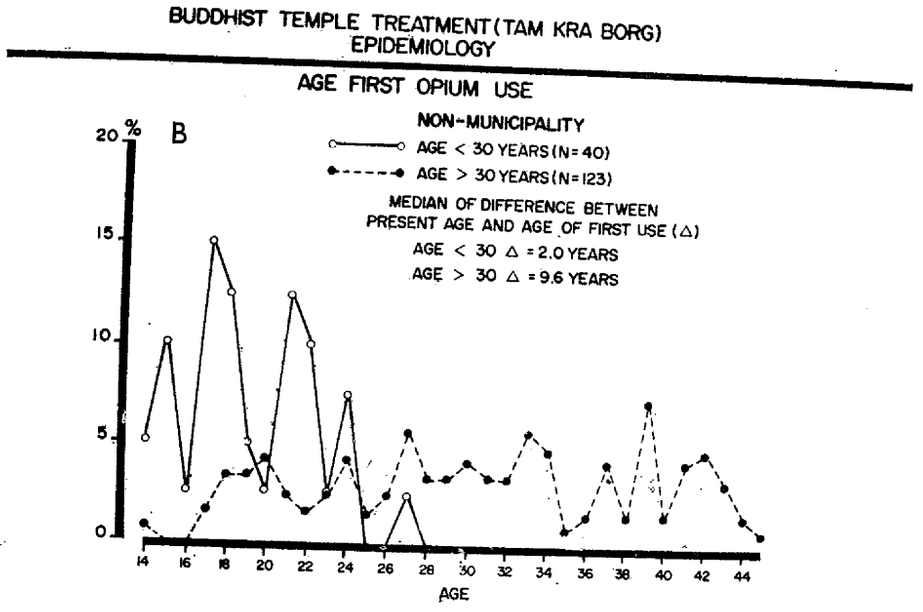


FIGURE 5 The age and year of first heroin use of the drug dependence patients, the Buddhist Treatment Center, Tam Krabrog, Saraburi.

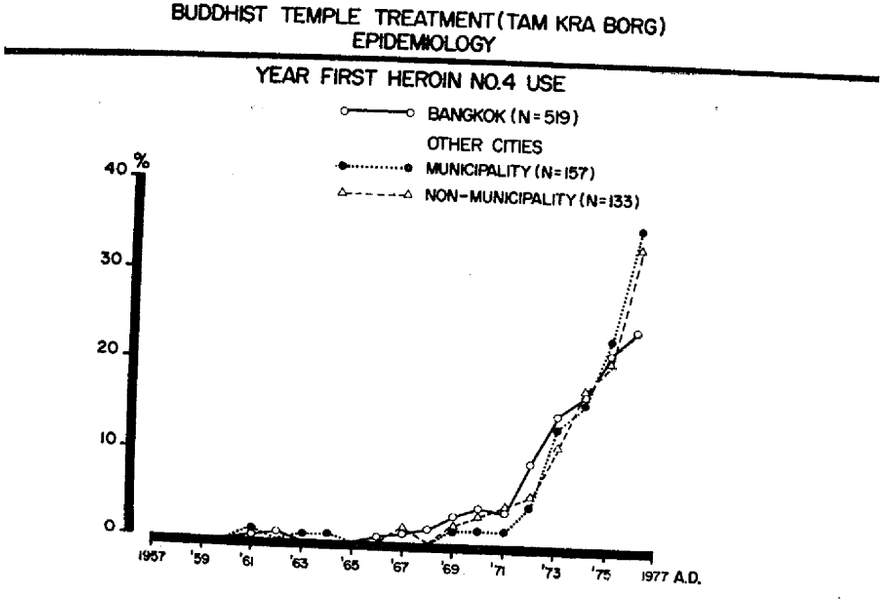


FIGURE 5

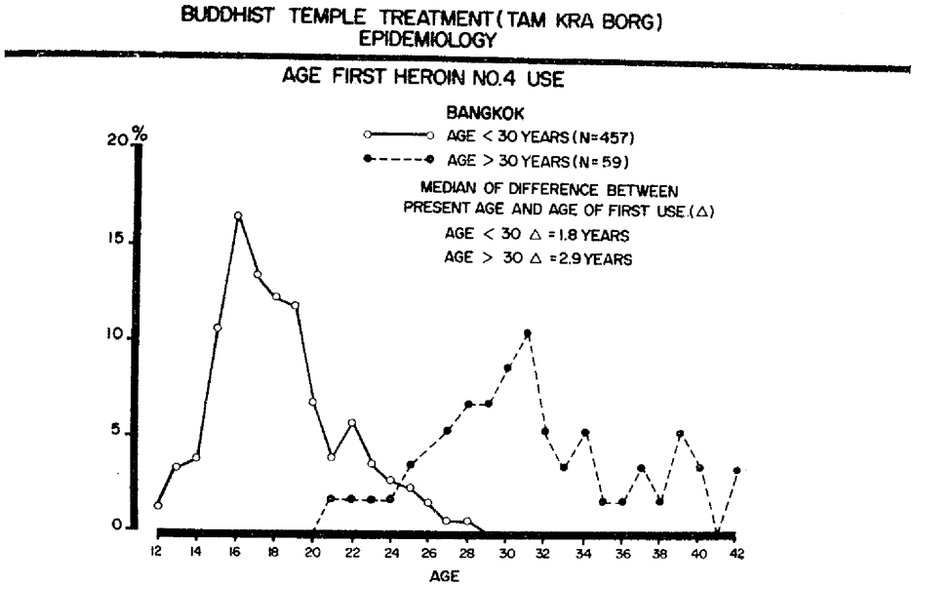


FIGURE 5

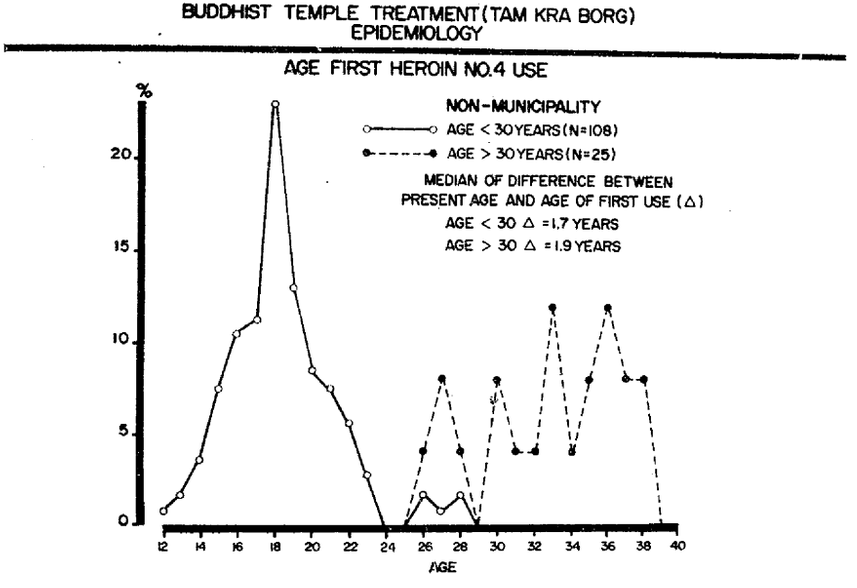
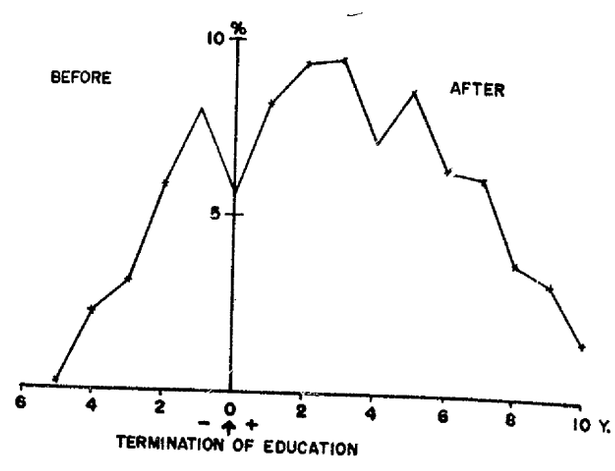
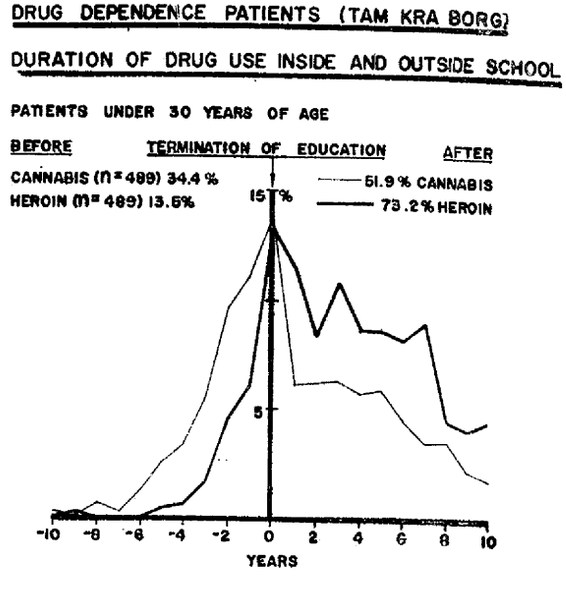


FIGURE 6. Duration between first daily drug use and termination of education.





DRUG USE AND ASSESSMENT METHODOLOGY IN THE UNITED STATES

By

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U. S. A.

Surveys

National survey of general populations. The most recent national household survey of non-medical drug use was conducted in 1975-76 (I). It involved a representative sample of 986 youth, age 12-17, and 2590 adults, age 18 and over. Data on life time prevalence of any use, and use within the month prior to interview are presented in Table 1. The majority of young adults, age 18-25 have now tried marihuana and 25% used in the previous month. As seen in Table 2, the percentage of adult males using marihuana is about twice that for females, although the difference is smaller among youth. Marihuana use is largely limited to youth and young adults-only 6% of those 35 and over have ever used the drug, and only 1% used within the previous month. Differences in use among racial groups are not large; however, there is substantially greater use among those with higher education. This latter finding reflects the fact that the marihuana epidemic of the late 1960's began with the young middle class counter-cultural movement of that period, and later attracted large numbers of youth from a similar socio-economic status (II). This phenomenon subsequently spread to educated youth in many other countries throughout the world.

TABLE I

Prevalence of Drug Use — Nationwide Sample[a]

Drug	Youth, Age 12-17		Adults, 18 and Over		Adults, 18-25	
	Ever Used %	Used in Last Month %	Ever Used %	Used in Last Month %	Ever Used %	Used in LastMonth %
Marihuana	22	12	21	8	52	25
Inhalants	8	1	3	*	9	0.5
Hallucinogens	5	1	5	*	17	1
Cocaine	3	1	4	1	13	2
Heroin	0.5	*	1	*	4	*
Other opiates	6	2	5	0.5	14	1
Sedatives[b]	3	*	4	1	12	2
Tranquilizers[b]	3	1	4	1	9	3
Stimulants[b]	4	1	8	1	17	5

[a] From: Abelson and Fishburne, Non-medical use of psychoactive substances.

[b] Non-medical use of prescription drugs.
*Less than 0.5%.

TABLE 2

Prevalence of Marihuana Use — Nationwide Sample[a]

Characteristic	Ever Used	Used in Last Month
Youth - age 12-17		
Age		
12-13	6	3
14-15	21	13
16-17	40	21
Sex		
Male	26	14
Female	19	11
Race		
White	22	12
Non-white	22	11
Adults - age 18 and over		
Age		
18-21	52	25
22-25	53	25
26-34	36	11
35+	6	1
Sex		
Male	29	11
Female	14	5
Race		
White	21	8
Non-white	25	10
Education		
Not high school graduate	12	4
High school graduate	22	8
College	30	12

[a] From : Abelson and Fishburne, Non-medical use of psychotropic substances.

Drug use among nationwide high school seniors. Table 3 shows the rate of non-medical drug use among a representative sample of male and female high school seniors (grade 12) for surveys conducted in 1975, 1976 and 1977 (9). The samples were quite large, ranging from 9000 in 1975 to 17,000 in 1977. It will be seen that, although a substantial percentage of these youth have used a number of drugs on an occasional basis, the only ones used on a daily or near daily basis are tobacco, alcohol and marihuana. Marihuana use is continuing to increase, whereas usage of other drugs has been stable over the past three years. It is of interest to note that daily use of marihuana (9%) now exceeds similar usage for alcohol (6%) in this group. In the early period of the middle class drug epidemic in the U. S., marihuana was almost entirely limited to less-than-daily use consistent with the faddish nature of the phenomenon. Now, appreciable numbers

of youth and young adults are using the drug daily. On the other hand, the quantity consumed is still generally quite small in comparison to that taken by chronic cannabis users in countries where use has been indegenous for centuries. Data on amount consumed are not available from the surveys cited here, but other information suggests that the average amount of the active ingredient (delta 9 tetrahydrocannabinol) consumed by daily U. S. users is of the order of 5-15 mg. compared to 40-50 mg. for daily users in traditional cannabis-using cultures (11). Of course, heavy consumption patterns may also develop in the U. S. with continued experience with the drug.

Drug use among males, age 20-30. In 1974 a comprehensive interview study was done of a representative national sample of 2500 males drawn from the selective service register (17). This approach has certain advantages over the household survey method, since heavy drug users are likely

TABLE 3

Trends in Drug Use Among High School Seniors (Grade 12)[a]

Drug	% Ever Used			% Used in Last Month			% Used 20 or More Times in Last 30 Days		
	1975	1976	1977	1975	1976	1977	1975	1976	1977
Marihuana	47	53	56	27	32	35	6.0	8.2	9.1
Inhalants	NA	10	11	NA	1	1	NA	0.0	0.0
Hallucinogens	16	15	14	5	3	4	0.1	0.1	0.1
Cocaine	9	10	11	2	2	3	0.1	0.1	0.1
Heroin	2	2	2	*	*	*	0.1-	0.0	0.0
Other opiates[b]	9	10	10	2	2	3	0.1	0.1	0.2
Stimulants[b]	22	23	23	8	8	9	0.5	0.4	0.5
Sedatives[b]	18	18	17	5	4	5	0.3	0.2	0.2
Tranquilizers[b]	17	17	18	4	4	5	0.1	0.2	0.3
Alcohol	90	92	92	68	68	71	5.7	5.6	6.1
Cigarettes	74	75	76	37	39	38	26.9	28.8	28.8

[a] From : Johnston, Bachman and O'Malley, Drug use among American high school students, 1975-1977.

[b] Non-medical use only.

* Less than 0.5%.

to be underrepresented in the latter. The prevalence data are presented in Table 4, and again indicate large proportions exposed to various drugs, but significant recent and heavy usage is limited to tobacco, alcohol and marihuana. Eleven percent had used marihuana within 24 hours preceding the interview; however, unlike the high school senior data, this does not approach the percentage using alcohol within the same period (46%). Within the 20-30 age group, marihuana usage was substantially heavier among those in the early 20's. If light or experimental users are excluded, 37% of those age 20-24 reported use compared to only 12% of those age 29-30.

Six percent of the sample reported having used heroin one or more times, and 1.9% indicated daily use at some time. Of the 1.7% reporting addiction to heroin at some time, about one-third had been in treatment.

Drug use in a California county. One local drug survey of students in San Mateo County, California is of interest because, (1) the locale resulted in early exposure to the drug epidemic of the 1960's and (2) it has been conducted on an annual basis since 1968 (2). San Mateo County is adjacent to San Francisco, and thus had an earlier and more pronounced exposure to the countercultural movement and associated drug use than did most other areas of the U. S. For instance, one year after the Gallup poll found 5% of nationwide college students had used marihuana (1967) the comparable percentage for senior males in San Mateo County high schools was 45%. Fig. 1 shows the percentage of eighth and eleventh grade (juniors) using marihuana one or more, 10 or more, and 50 or more times during the preceding year for the period 1968-77. The percentage using the drug at least once during the year is continuing to rise; however, the percentage using an average of once a week or more has been relatively stable for several years. At the present time, marihuana usage in this

TABLE 4

Prevalence of Non-Medical Drug Use Among A National Sample of Males, Age 20-30 [a]

Drug	Ever Used %	Used in Last Month %	Used in Last 24 Hours %
Tobacco	88	55	50
Alcohol	97	85	46
Marihuana	55	26	11
Hallucinogens	22	2	0
Stimulants	27	5	1
Sedatives	20	3	0
Heroin	6	1	0
Other opiates	31	2	0
Cocaine	14	2	0

[a] From: O'Donnell et al., Young men and drugs - A nationwide survey.

area is not substantially above the nationwide rates (Table 2). This survey also collects annual data on amphetamine, barbiturate, LSD and heroin usage rates - all of which have been stable or dropping slightly in the past several years.

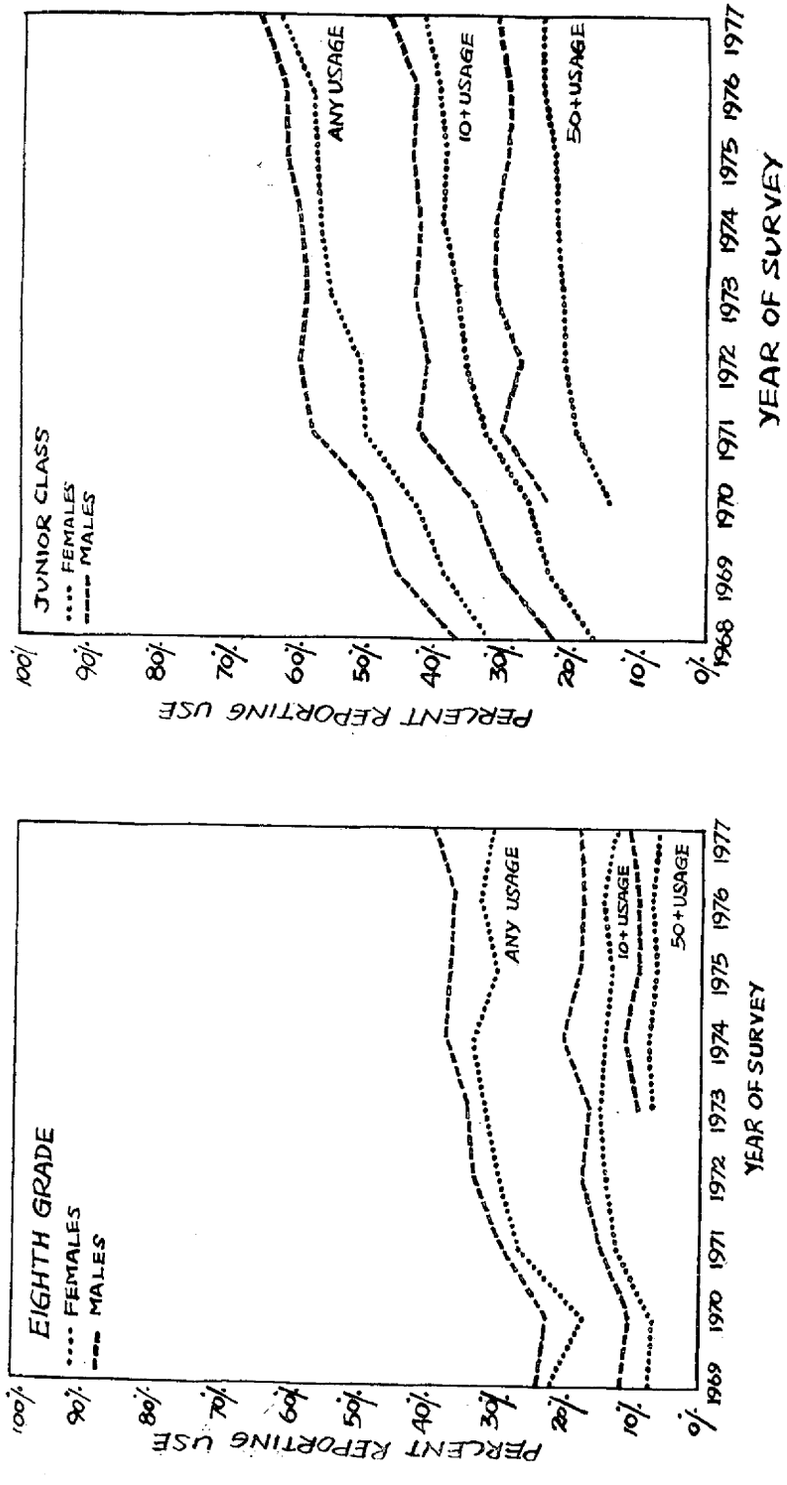


FIGURE 1 LEVELS OF MARIJUANA USAGE
1968 - 1977
SAN MATEO COUNTY CALIFORNIA, STUDENTS

One aspect of this survey that should be emphasized is the extent to which informative trend data can be inexpensively collected by annual administration of a very brief set of questions. The survey covered the total population of students each year, utilizing a uniform questionnaire about the size of a post card. For each drug, the student was simply asked if he or she had used it one or more, 10 or more, or 50 or more times in the past year. The questionnaires were anonymous, made little imposition on the students or teachers, collected the same information each year on the same population, and were quite inexpensive. By virtue of covering a ten-year period in a uniform manner, it yielded useful information not provided by much more extensive one-time surveys.

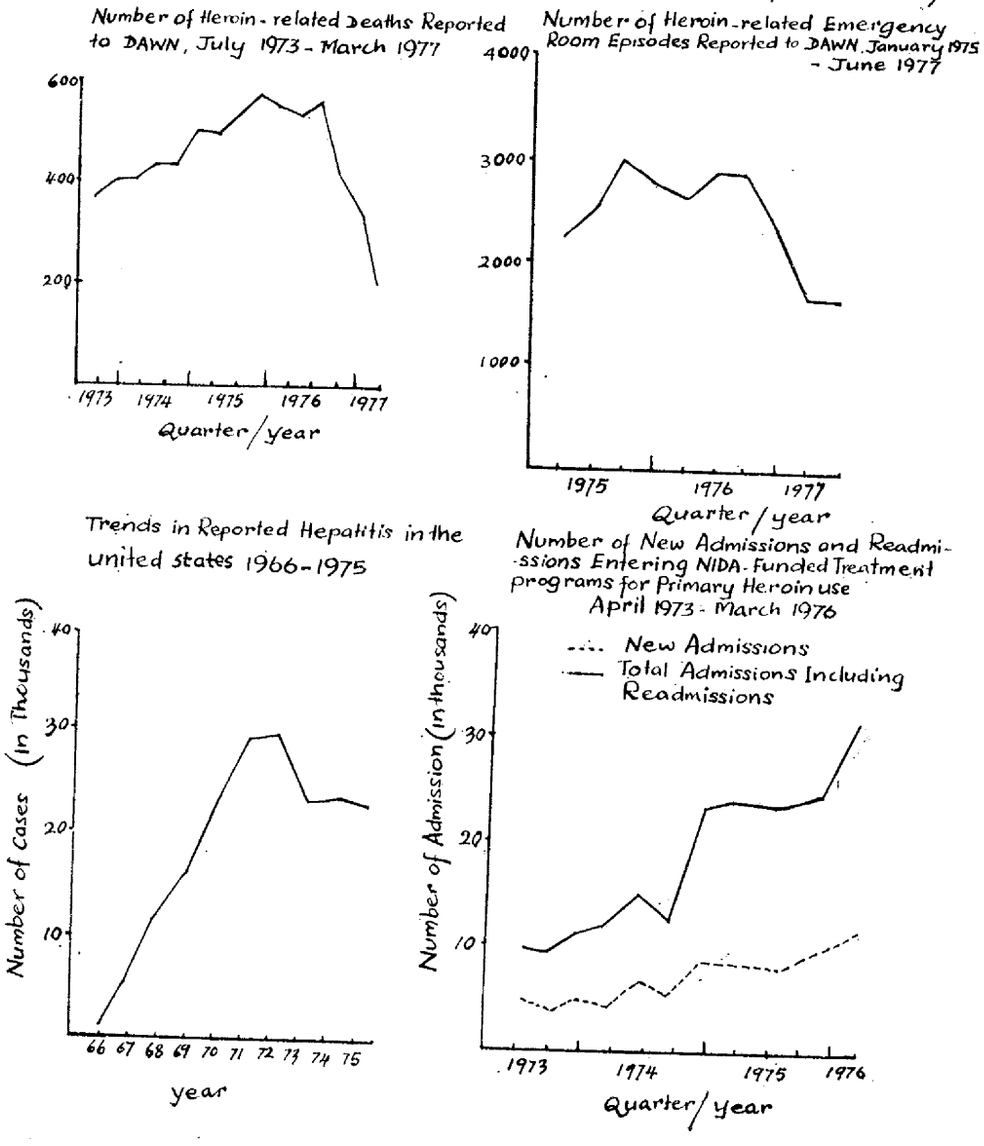
Heroin Use Indicators

While the survey methods described above are well suited to measuring the prevalence and frequency of marihuana and other drug use in open and accessible populations, they are not adapted to assessing chronic use of heroin and certain other drugs. The problem involves the sampling limitations. While student and household surveys record a small amount of mostly casual heroin use, they do not adequately sample the street addict population who are neither students nor readily identifiable members of sampled households. For this reason, various other assessment methods have been employed, most of which are indicators that show trends over time rather than absolute numbers of users.

In addition to the problems of measurement, there are also difficulties in defining the population to be counted. In the U. S. there are many more persons who use or have used heroin than there are addicted at a given point in time. In the survey of males, age 20-30, 6% reported having used heroin at some time, which translates to some 1.1 million in this age group alone. Many of these never become addicted. For those who do become physically addicted, the phenomenon is typically intermittent rather than continuous. In the U. S., and probably other countries where the opiate addict is subject to extensive coercion, addiction careers are frequently punctuated by periods of abstinence or less-than-daily use resulting from incarceration, treatment, legal supervision or other reasons. In addition, the coercion directed toward the addict results in the maturing out phenomenon observed in the U.S., but not in countries where opiates are used under conditions of social acceptance or toleration. Thus, there is the issue of defining when an individual ceases to be an addict. From the standpoint of estimating the number at risk, the population should probably be defined as those having used the drug and who have not permanently discontinued. In terms of social cost of addiction it is more meaningful to estimate the number who are physically addicted at a given point in time, since it is this group that contribute most heavily to property crime - at least in the U.S. (13). The following subsections will briefly describe the major heroin use indicators utilized in the U. S.

Addict registers. In theory, it would be possible to compile a reatively complete list of persons significantly involved in heroin addiction since the large majority come to the attention of official enforcement or

Figure 2. Trends in Heroin Use Indicators (From National Institute on Drug Abuse, Heroin Trend Indicators, July 1976, and DAWN Quarterly Report, April - June 1977)



health agencies. It would be more difficult to devise a satisfactory means of deleting those who are no longer active addicts. In practice, attempts to maintain addict registers in the U. S. have not been very successful because of the lack of full cooperation of the various data collecting agencies as well as the lack of procedures for purging outdated information.

There have been only two major attempts to establish registers - one Federal and one in New York City. The Federal register depended on reports by local law enforcement agencies and, although still maintained, is notoriously incomplete. The files are purged if there is no report of addiction within a five year period. The New York City registry received information from both enforcement and health agencies but there was no systamatic means of deleting cases other than through death records. While a well administered registry can provide valuable information for planning and for epidemiological studies (15), they are not a significant resource at present. Confidentiality restrictions are one of the main deterrents to future efforts in this area.

Heroin overdose deaths. The best known heroin use indicator is derived from deaths attributed to heroin overdoses. The Baden formulae of 0.5% overdose deaths per year among addicts provides a simple estimate of the population, i.e. 200 times the number of known deaths (18). Death rates among known populations of addicts from all causes are typically around 1.0-1.5% per year, and about one-half of these are attributed to overdoses (12,19). Overdose deaths appear to be the best single indicator; however, other factors such as the purity of available heroin may markedly affect the rate. Data reported from approximately 100 coroners in the Drug Abuse Warning Network (DAWN) are shown in Fig. 2(4,14). The precipitous drop in overdose deaths beginning in the third quarter of 1976 is unprecedented, and is generally attributed to the very low purity of street heroin resulting from the recent suppression of opium cultivation in Mexico. Although precise data are not yet available, it is known that the low rate of overdose deaths continued throughout 1977. Whether the sharp decline in overdose deaths is due to a decrease in use or the lower toxicity of the available drug has not yet been established.

Emergency room cases. In addition to deaths attributed to heroin and other drugs, the DAWN reporting system provides regular data on drug-related emergency cases addmitted to some 650 facilities in 24 major metropolitan areas. The main purposes of this system are twofold, (1) to provide trend data on the extent of medical problems arising from the use of various known drugs of abuse, and (2) serve as an early warning of new drugs being used for non-medical purposes. The number of emergency cases resulting from heroin use shown in Fig. 2 is for a shorter period than the graph on deaths, but the data closely parallel the overdose decline beginning in the latter half of 1976.

An example of the use of the DAWN system for detecting abuse of new drugs is provided by recent data on emergency room admissions for phencyclidine (PCP) use. This is an animal anesthetic that has some hallucinogenic properties, and has recently been reported to be a serious

problem in certain areas. These informal reports are confirmed in the DAWN surveillance. For instance, in Los Angeles, California there were only 11 PCP emergency cases reported during the first half of 1975 compared to 228 in the same period for 1977 (4).

Hepatitis rates. The sharing of injection paraphernalia is known to be one of the major means of spreading serum hepatitis, and the majority of addicts contract this disease at some time. The steep rise in reported cases from 1966 to 1971 (Fig. 2) parallels a known increase in heroin addiction during this period. The increase in infectious hepatitis (not shown) shows only moderate increases during the same period. The peak in serum hepatitis cases in 1971-72 does not match the overdose death data. It has been suggested that since permanent immunity apparently follows a single episode of serum hepatitis, the number of such cases may be more closely related to incidence of new heroin use rather than overall prevalence. This would accord with other evidence showing that the recent epidemic of new cases of heroin use peaked around 1968-69 (6).

Overall, however, the hepatitis indicator seems to be a more erratic and less accurate indicator of heroin use than are overdose deaths. Part of the problem is probably related to difficulties in identifying serum hepatitis cases, and the lack of consistent reporting over time.

Treatment entries. The number of admissions to heroin treatment programmes is another indicator of heroin use, although this is also a function of treatment availability, court referrals to treatment, and other factors. The rise in treatment admissions seen in Fig. 2 parallels the rise in overdose deaths. Official data on treatment entries for the period of recent decline in heroin overdose deaths and emergency episodes are not available, but informal information indicates that this indicator has also been falling over the past year. This latter finding is somewhat difficult to interpret, since it might be expected that the current high prices and very low purity of street heroin would force more addicts into treatment. On the other hand, several local efforts to reduce the availability, and increase the price of heroin, have generally shown a similar lack of relationship to treatment admissions. There is evidence that reduced availability and low heroin purity is related to the switching to other injectable drugs such as methyphenidate (10). This explanation is consistent with the fall in heroin overdose deaths and emergency cases in the past year.

Treatment entry data have also been utilized to retrospectively establish the rate of incidence of new heroin use. Intake data routinely includes the age of first heroin use which can readily be converted to graphs showing incidence by calendar year. These data have generally shown a large peak around 1968-69, although the maximum incidence tended to occur later in smaller communities (8). By adjusting for the lag between incidence of first use and treatment entry, it is also possible to predict future treatment admissions based on the incidence distribution for current entries.

Criminal justice measures. Arrests for heroin use, possession and trafficking provide another indicator of prevalence of use; however, this measure is also strongly related to enforcement efforts which fluctuate widely depending on the existing police policy. Data on heroin and other drug seizures are similarly erratic because of variations in police efforts and the distortions of the statistics resulting from exceptionally large seizures.

Data on the percentage of arrestee urine specimens containing morphine (heroin) provide reliable data on heroin use among this population. Since U.S. heroin addicts are subject to frequent arrest, this would be an effective means of estimating prevalence, but has only been minimally employed (5,10). In New York City, data have been maintained on the number of arrestees showing evidence of physical dependence on opiates since 1971 (16). The percentage has averaged around 25-30. Other data on the number of heroin users in the criminal justice system are provided by a 1974 national survey of prison inmates (3). Thirty percent reported having used heroin, 21% had used daily and 14% were addicted at the time of arrest.

Finally, the number of arrests for burglaries and other theft has been used to estimate the prevalence of active addicts. Arrest rates for these offences can be determined for samples of known addicts, and the percentage of arrests accounted for by addicts can be estimated by urine testing data.

Indicator dilution models for estimating heroin use.* This is sometimes referred to as the capture-recapture method of estimation. It has been employed to estimate the number of addicts by determining the number reported to the Federal registry during one period, and then obtaining the proportion of this number that are reported again during a subsequent period (7). This approach provides an estimate of absolute prevalence in addition to trend data. For 1975, the estimate was some 550,000. There are several problems with this approach—the main one being the assumption that the probability of the second arrest is independent of the first arrest.

Another example of this method is the combined utilization of heroin user mortality and registry data. The proportion of deaths known to the registry permits a correction for incompleteness in the registry files. This also provides an estimate of absolute prevalence. Any of these methods of estimating absolute prevalence are subject to the problems of definding what constitutes a case of heroin addiction to be counted, as well as the limitations imposed by the statistical assumptions.

* This is a standard statistical technique with various applications. One easily understood example is its use to estimate the number of fish in a lake. A number of fish are netted and tagged and then replaced. A second netting is then obtained, and the proportion of tagged fish allows an estimate of the total number of fish in the lake.

Regression model. Recently, a more sophisticated statistical model has been applied to estimating heroin use based on the relative standing of a number of metropolitan areas on several indicators such as overdose deaths, emergency room entries and treatment admission (18). Data were obtained from the 24 areas participating in the DAWN system, and regression techniques were employed to obtain an overall ranking of heroin indicators per 100,000 population. Independent estimates of absolute heroin prevalence were then obtained for two areas at the lower and upper ends of the regression line. This, in turn, permitted prevalence estimates for the remaining areas. The weakness in this approach lies in the estimates of prevalence for the anchor points.

Conclusions. Probably the most obvious conclusion from the above discussion is that attempts to measure the absolute prevalence of heroin addiction are severely hampered by, (1) problems of defining what constitutes a case to be counted, and (2) methodological problems in converting indicator data to prevalence estimates. Relatively reliable data on trends in heroin use indicators can be obtained, and are sufficient for most policy and planning decisions.

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Discussions

The discussion on the paper by DR. V. NAVARATNAM "National Data Bank on Drug Abuse" is summarised as follows :

1. It is possible to bring the records of an individual reported by the same or different agencies together to provide a total profile of the individual. This is done by using a collapse programme.

2. Concern was expressed by some participants on the issue of the possibility of breaching individual confidentiality. In this respect, it was stated that the system was established by Government decision and is insured by the Cabinet Committee on Drug Abuse Control so that no violation of individual liberty would or could occur.

3. It was also stated that the usefulness of the system is as good as the input data. But one has to bear in mind that when developing a national monitoring system, no single reporting source reflects accurately the total magnitude and nature of the problem in the country. Each reporting agency reveals only a part of the situation none being representative of the whole. Hence, it is clearly necessary to integrate the reporting and recording system.

The report from Singapore on "The use of law enforcement statistics in drug abuse assessment' was presented by MR. FOO CHIA CHOW. Questions were asked by several participants concerning the validity of urine tests. These questions were discussed extensively.

Summary of the discussion following the paper presented by DR. VICHAI POSHYACHINDA :

1. Some indicators for socio-economic patterns are surely the most desirable elements in any drug dependence study. These parameters had been purposely deleted from this presentation because of the limited objectives stated at the beginning of the report

2. The final result of each research study together with the interpretation and recommendations was reported directly to the institutions where the data was collected. At the same time, it was sent into the Office of the Narcotics Control Board, under the Office of the Prime Minister and the Ministries responsible for the respective institutions.

3. The interpretation of the research project result was carried out taking into account the opinion of the drug dependence research team and finally decided upon by the researchers directly responsible to the particular project. Explanation is appropriate here on the presentation format. It was presented in two well separated sections, one was the fact in terms of figures as revealed by the data gathering and the other, the interpretation which had been based upon those figures. This practice gives an opportunity for any individual or institutions to furnish their own interpretation and/or evaluate the offered interpretation and recommendations objectively.

4. Opium is without doubt an indigenous drug as shown by the recurring episodes of national crisis and law enforcement control documented in the history of the country. It was mentioned here in two contexts, one as an indicator of the recent drug dependence epidemic and another as a research finding relevant to the nature and extent of current opium dependence.

5. The criteria for overdose death in the case of heroin has not yet been established. To raise just one aspect regarding diagnosis, the heroin dependent could develop tolerance to the drug to an high level not possible to estimate so that on post mortem examination it would be extremely difficult to find any objective evidence to prove an onverdose death. At this stage, it would be unwise to rely on the statistics of deaths from overdose.

6. The present situation as demonstrated by the epidemic pattern still indicated an active dynamic change in the opiate users population.

The questions raised by PROFESSOR W. MCGLOTHLIN's paper on "Drug Use and Assessment Methodology in the United States" were as follows:

1. *What are the "core" items used in household surveys?*

   Very simple questions such as :

   (a) Have you ever used marihuana ?
   (b) Have you used marihuana in the past week, etc.?
   (c) Other basic demographic information such as :

      (1) Age
      (2) Sex
      (3) Occupation
      (4) Education
      (5) Size of Community

2. *What are the socio-economic effects of heroin and cannabis use in the U. S.?* Major socio-economic effects of heroin use are the cost of enforcement, treatment and property crimes related to the obtaining of money to purchase the drug. Trafficking also contributes to the support of large scale organised crime and the corruption of enforcement officials.

3. *How are heroin overdose cases handled and how reliable is the determination?* Studies of the accuracy of such diagnosis have shown considerable variation in the criteria for attributing death to overdose. However, the Drug Abuse Warning Network (DAWN) utilizes approximately 100 coroners on a regular basis, so the trends in reporting should be fairly reliable.

4. *Considering the fact that the purity of street heroin varies, and different adulterants may be used, why is the overdose rate considered a stable measure?* One of the suspected reasons for overdose death is the variability and uncertainty associated with the purity of the drug. Since the user has no reliable information as to potency, he or she may unintentionally consume a lethal dose. The overall purity of street heroin has been very low in the past 18 months. This may be one of the reasons for the unprecedented drop in overdose death rates during this period. The alternative explanation is that many heroin users have discontinued use or switched to other drugs. Probably both factors are contributing to the sharp decline in death rates.

PART FOUR

Treatment and Rehabilitation—Workshop Papers

DEVELOPING AN INTERNATIONAL METHODOLOGY FOR EVALUATION OF TREATMENT AND REHABILITATION APPROACHES

By

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The need for a practical methodology for evaluating treatment and rehabilitation approaches was brought to the attention of WHO in the process of implementing UN/WHO Country Programmes for Drug Dependence. In planning these programmes national authorities as well as WHO consultants and staff observed a lack of published scientific information on the effectiveness of drug dependence treatment methods in developing countries. The evaluation studies which were available were invariably carried out in industrialized countries. Before they could be applied in developing countries they would have to be evaluated in these settings. In addition the developing countries were exploring promising new approaches as well as traditional indigenous treatment methods, and these would require careful evaluation before they could be implemented on a larger scale.

It was clear that a practical methodology was needed which could be used to evaluate different treatment and rehabilitation approaches, for different types of drug users and in different socio-cultural settings. To meet this need, a pilot feasibility study was carried out in 1976 by the UNFDAC supported WHO Research and Reporting Project on the Epidemiology of Drug Dependence.[1,2] Baseline and one month progress forms were tested on small samples of patients in eight countries. In reviewing the results, it was recognized that no standard instrument could be expected to evaluate treatment outcome variables that are unique to a specific method of therapy or to specific socio-cultural conditions. However, it was felt that there were a number of core outcome measures that would be important to record in evaluating the majority of drug dependence treatment methods regardless of socio-cultural setting. It was therefore decided to test these core items along with additional optional items in pilot treatment evaluation studies.

During the next phase of work, completed in 1977, second generation baseline and progress instruments were tested on small samples of subjects who were assigned to treatment services according to pilot treatment evaluation study designs. This permitted collaborating investigators at their next meeting[3] to review the use of the modified instruments as well as the individual study protocols of participating centres.

In the current stage of work, the pilot research is being expanded into full scale evaluation studies in five countries. They are expected to generate sufficient six month follow-up data to permit the methodology to be finalised in early 1979 for later publication and widespread application. While the primary objective of this study is to develop an operational methodology, it is also serving as a mechanism to generate systematic studies in developing countries where there has previously been relatively little scientific data on the effectiveness of treatment and rehabilitation methods for drug dependence.

Discussion :

Because our colleagues from the Universiti Sains Malaysia will be describing in the course of this Seminar, a pilot study in which this WHO methodology was applied, it will not be useful to go into greater detail concerning the instruments or the deliberations of collaborating investigators at review meetings. It might be of interest, however to share with you some observations on the types of studies designed by collaborating investigators and on some advantages and shortcomings in such international studies.

The evaluation studies now being implemented by collaborating institutions encompass a wide range of drug use patterns and populations; they include young urban heroin users, rural adult opium smokers, psychotropic drug abusers, and heavy cannabis users hospitalized for acute psychoses. Each centre has developed its own protocol to meet the particular needs of its study. The study designs include a rather complex double blind study, a simple follow-up study, and comparisons of subjects randomly assigned to either of two treatments.

One striking similarity in all of the studies is the emphasis upon comparing different detoxification procedures. This emphasis upon the withdrawal phase of treatment may in some settings be the only treatment currently available. Elsewhere it may reflect the total lack of social rehabilitation and after-care services for drug users. In other settings it reflects a cautious and deliberate examination of the efforts of detoxification alone, before expending additional scarce resources on more costly comprehensive programmes. One suspects that the next generation of studies will include evaluation of after-care and rehabilitation approaches as the need for such services becomes fully appreciated.

The choice of treatment approaches being evaluated also reflects the encouragement of collaborating investigators to evaluate the treatment approaches currently available to drug users in their community and particularly those low cost approaches that would be suitable for widespread application by national governments if they were found to be effective. Although collaborating investigators were familiarized with recent trends in treatment programme developments in industrialized countries they were encouraged to give priority to approaches that had been innovated locally, including promising indigenous treatments.

These collaborative evaluation studies depart deliberately from the concept of the cooperative cross-national study, that is a study in which the identical treatment is tested on subjects chosen by the same criteria and evaluated by the same measures in different cultural settings. Although such cooperative studies may be indicated at a future date, it was not feasible at this stage in the development of the network of collaborating institutions. There are far too many differences in the patterns of drug use, in the populations affected, and in the treatment methods, facilities and personnel available in the respective centres to launch such an ambitious effort, even if it were justified at this particular time.

While the WHO methodology for treatment evaluation is certain to undergo additional modifications before it is finalized during the coming year, the pilot work already carried out in Malaysia suggests that it will be applicable in the countries of this region. When the finalized methodology becomes available for application it should permit WHO to collaborate with Governments in other parts of the world to more rapidly implement treatment evaluation studies, even in remote areas. An International team of WHO consultants and collaborating investigators will be familiar with the system, and countries which do not have computer services should be able to have their data analysed either by WHO or by a collaborating institution which has already developed the data processing technology appropriate for this work.

There are limitations associated with participation in such collaborative studies. Some individual investigators can organize and complete studies much more rapidly than the slow timetable required by international communication and administration. Earlier we mentioned that the unique qualities of a treatment programme and unique outcome variables may not be measured by non-specific international instruments. Certainly some researchers prefer not to go with the crowd; they may not need assistance in developing methods, or they may feel that their subject matter requires an individualized approach. Still, there are obvious advantages for many investigators and planners in developing countries who wish to short-cut the cost and time involved in developing their own methodologies. By developing a methodology collaboratively, the cost and effort are shared, but there are additional advantages. In a manner similar to that provided by this Seminar, the collaborative framework permits key technical experts in concerned countries to meet with one another to share information on the solution to common problems. Because they use similar methods and collect comparable data, they speak the same language in technical discussions. When the efforts of individual collaborating centres are combined, they have an addative effect, that is of an international team sharing information and resources in pursuit of the common objectives.

As the results of these independent and collaborative studies identify ineffective approaches, they can be discarded and clinical resources can be directed toward the most promising approaches. Decision making and planning for clinical services can increasingly be carried out on the basis of scientific data, rather than on the basis of highly emotional or ideological debate.

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ACKNOWLEDGEMENT

The author gratefully acknowledges the contributions of the following collaborating investigators on the WHO Research and Reporting Project on the Epidemiology of Drug Dependence:

Professor A. Anumonye, College of Medicine, University of Lagos, Lagos, Nigeria

Mr Lee Boon Aun, Centre for Policy Research, University Sains Malaysia, Penang.

Dr Chitr Sithi-amorn, Chulalongkorn University, Bangkok, Thailand

Mr R. Cutler, Water Street Research Group, Vancouver, Canada

Dr L. Johnston, University of Michigan, Ann Arbor, Michigan, USA

Dr U. Khant, Rangoon Psychiatric Hospital, Rangoon, Burma

Ms. Maria Elena Medina Mora, CEMEF, Mexico City, Mexico

Dr V. Navaratnam, Centre for Policy Research, Universiti Sains Malaysia, Penang.

Dr P. Renault, National Institute on Drug Abuse, Rockville, Maryland, USA

Dr R. Salan, Directorate of Mental Health, Ministry of Health, Djakarta, Indonesia

Dr M. Shafique, Khyber Medical College, Peshawar, Pakistan

Dr R. G. Smart, Addiction Research Foundation, Toronto, Canada

Dr V. K. Varma, Postgraduate Institute of Medical Education & Research, Chandigarh, India

Dr Vichai Poshyachinda, Chulalongkorn University, Bangkok, Thailand

Mr K. A. Wadud, Pakistan Narcotics Control Board, Islamabad

TREATMENT OF DRUG DEPENDENCE IN SRI LANKA

By

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This paper briefly states some of the characteristics of opium addicts in Sri Lanka and the problems we had in their treatment - more appropriately their detoxification.

Firstly, I would like to describe the setting in which this treatment was given. One is a large mental hospital having about 2,500 patients both short stay and long stay. This is situated in a place called Angoda and was built in 1925. Until about 15 years, ago, this was the only mental hospital in the island, so much so that word Angoda is synonymous with madness. There are closed as well as open units housed in three storeyed blocks. The other is a smaller hospital with 300 beds, all in open units mainly for short stay patients. These two hospitals are situated close to each other, about 6 miles from the city of Colombo. The out-patients clinics are all held in the General Hospital situated in the city. There are six Psychiatrists attached to these hospitals. We have only one Psychiatric Social Worker. Besides these two hospitals, we have seven psychiatric units attached to general hospitals throughout the island.

I must state at the outset that no conclusions can be drawn from the admission of drug addicts to these two mental hospitals, either about the incidence or the pattern of drug dependence in the country.

Ganja (marijuana) is widely grown in the country. I think its consumption is popular among some sections of the population but we haven't treated any one for ganja addiction as such. We have come across some psychotic patients who had resorted to ganja. A handful of addicts of drugs, other than opiates, have sought treatment from us. Of the opiates, it's mainly opium. There are a few morphine and pethidine addicts mostly among the medical and nursing professions, and no cases of heroin use.

Up to about the end of 1974, very few opium addicts sought psychiatric treatment. In 1973, a drug adviser was appointed to the Colombo Plan Bureau. In 1974, the police set up a Narcotics Bureau. At about this time, the Indian Customs and our officials tightened up on smuggling between India and Sri Lanka. All the opium comes into the island from India. As a result of this action by the Customs, there was a shortage of opium and the prices shot up. It is estimated that there are about 15,000 addicts in the city and the suburbs. The personnel of the Narcotics Bureau had identified some of them and on their advice they started coming to us for treatment. The press carried articles on opium dependence and the availability of treatment. In the latter half of 1975, we had 101 admissions to the two mental hospitals. There were 153 admissions in the first half of 1976.

We made a pilot study of fifty consecutive admissions to these hospitals in 1976. Two thirds of them were over the age of 50 years, the oldest was 85 years old. Almost all the patients were from the lower, socio-economic group, two thirds of whom had not proceeded beyond primary school education. Only 11 were from urban areas, the rest were rural people. Well, about 80% of our population is rural. Two thirds of our patients gave a history of addiction of more than 20 years. When we looked into the age of first use, there were only two under the age of 21 years. Over half the number had started using the drug after the age of thirty, the oldest was at 73 years.

All the patients were asked as to how they first started taking opium. Sixty percent had taken it as treatment for some illness, often associated with chronic pain-backache, stomachache, chronic diarrhoeas, etc. Of the rest, over half admitted that they had taken it for the kick of it. Two had taken it as a cure for alcoholism. Of the group who said that they had taken it as a form of treatment, all claimed they had felt completely cured within a week or two of taking the opium.

Fifty percent denied taking any other drug. Others admitted to taking alcohol or ganja as well. There had been development of tolerence, but after a few years, majority of them had become capable of being satisfied with a fixed dose.

Ninety percent of our patients denied having any criminal record, but most of them said that they knew of other opium addicts who were given to petty thieving. Nearly two thirds of the patients stated that they had lost their standing in their community. They had a sense of guilt and shame. In many cases, this deterioration had taken place during the last few years the chief reason had been financial. They had to borrow money and could not keep their word in repaying the debts. Their family members generally showed disapproval of their habit, but had viewed them with some sympathy and tolerence. Majority of the patients had before their voluntary admission to hospital, made one or more attempts at self-cure but had failed.

On admission to hospital, none of the patients had symptoms of severe malnutrition or other physical illness. Neither were there any marked mental changes. The withdrawal sysmptoms were treated with methodone usually prescribed 10 - 15 mg. twice a day. The tablets were dissolved in water in order to avoid their smuggling. The dosage of methodone was reduced by quarter tablet daily, so that the patients received methodone for about 10 days. In addition to methodone, most patients were given diazepam at night. As the dosage of methodone reached towards the end most patients complained of pain and aches, inability to sleep, loss of appetite, etc. These symptoms were usually treated with chlordiazepoxide or chlorpromazine. The average length of stay in the ward was 18 days.

We experienced certain difficulties in the management of these patients in the wards. No separate ward had been set apart for them, and admission was to the general psychiatric wards. They did not join the other patients either in any activitiy in the ward or at the occupational therapy centre. They tended to congregate together with their mates in the other wards. The alcoholics too were treated in the same ward situation. But the opium addicts could not join their company either, for majority of the alcoholics were from a rather different socio-economic class. On the whole, the alcoholics were more educated, majority of whom could speak English. Hence the opium addicts remained an isolated group in the hospitals.

A significant find was the attitude of the ward staff towards these patients. There was a general resentment against them. The staff made frequent complaints about their behaviour, not being present at meal time, not getting into bed at time, etc. The staff felt with some justification that the presence of these addicts disrupted the ward routine and the therapeutic setting. We have six separate psychiatric units in each of the hospitals and some addicts got themselves discharged from one unit especially when the methodone was discontinued, and got themselves admitted to another unit sometimes under a different name. This tended to make the ward staff suspicious of all of them, and repeatedly questioned them about previous admissions.

On discharge from hospital, the patients were advised to attend the psychiatric follow up clinics at the general hospital but hardly any of them did so. We had no means to follow them up in the community. In short, we had only a detoxification programme, and no rehabilitation whatsoever.

About the latter half of 1976, we ran out of methodone, and the admissions of these patients came to a halt. Some time last year we obtained stocks of methodone however, we have had only a few admissions since then. There may be several reasons for this. I personally think that the opium addicts unless at his tether's end, does not wish treatment in a mental hospital setting at least, under the conditions we afforded them in Sri Lanka. And probably opium had again started flowing into Sri Lanka and the prices had dropped. Steps are now being taken to set up a separate unit for the treatment of drug dependents.

SOCIAL REHABILITATION OF OPIATE USERS

By

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Hongkong

I would like to express appreciation, on behalf of the Government of Hong Kong, for your invitation to attend this important meeting. We greatly value this opportunity not only to relay to you our present experience but also to learn from that of our neighbours in the region.

The historical background of narcotic addiction in Hong Kong is well known to all; indeed it may well be said, and not without some justification, that the very establishment of Hong Kong in the middle of the last century was based upon an unholy marriage of trade and opium, and that the benefits of the former and the scourges of the latter have remained with us ever since. The experiences of the past 150 years have taught us a great deal, but as with everything else, the accummulation of knowledge has gone hand in hand with the recognition of ignorance; and whereas we feel that our long experience may be of help to others, we are nevertheless the first to appreciate that we also have much to learn from our colleagues in other regions and situations.

The ultimate aim of the Government of Hong Kong in the field of narcotic abuse is its total eradication from our community. In a realistic appraisal of the situation however, we are well aware that total eradication of this entrenched problem is fraught with immense difficulties, and that it is necessary to set practical and short-to-medium term aims with the twofold objective of supply and demand reduction. In this respect our approach to the problem is essentially pragmatic, and we firmly believe that considerable progress can be made towards these objectives if systematic action is taken on the following points:-

(a) CAREFULLY CONSIDERED LEGISLATION.

(b) EFFECTIVE LAW ENFORCEMENT.

(c) ADEQUATE MULTIMODALITY TREATMENT FACILITIES.

(d) IMAGINATIVE PREVENTIVE EDUCATION AND PUBLICITY.

(e) SYSTEMATIC INTERNAL MONITORING OF NEEDS AND. TRENDS.

(f) CO-OPERATIVE INTERNATIONAL EXCHANGE.

Although this meeting is primarily concerned with treatment and rehabilitation, I mention these various factors, since we consider that all approaches to the narcotic problem are inter-related, and that overconcentration upon any one aspect to the exclusion of others will be fruitless.

It would be misleading to suggest that in Hong Kong we consider that we have the perfect system, we do not, but we do try to detect our own failings and we do try to correct them. In narcotics addiction we recognise that we have a long term problem, for which there does not appear to be any single, acceptable, ultimate solution in the foreseeable future. However, in spite of this pessimistic but nevertheless realistic appraisal, there are very strong indications that our methods are meeting with progressive success, and it would appear that we are at long last containing the problem.

In recent years we have enacted legislation to provide severe penalties for traffickers. We have made a systematic approach towards the eradication of corruption. Seizures of narcotics and associated materials continues to harrass traffickers, dealers and manufacturers, and thereby raise the price of drugs at street level* Such effective law enforcement action by the police and Customs and Excise, by raising the price at street level will induce the addict to seek assistance. Treatment and rehabilitation facilities have been expanded and developed to meet an assortment of requirements, so that there are today 13100 persons actively undergoing treatment, rehabilitation and after-care in our various programmes.

In the area of Preventive Education and Publicity, our aims are directed at deterring young people from ever experimenting with drugs. Regular anti-narcotics campaigns are being mounted as public displays and through the mass media. with the assistance of professionals and of ex-addicts. With these measures, the people of Hong Kong are becoming increasingly aware of the under-lying evils and causes of addiction, which is in turn developing a more positive attitude among the population at large. This has been strikingly reflected in the growing numbers of peoples who are willing to come forward to volunteer their assistance in the various anti-narcotics efforts which are being organised by the authorities.

On the international front we totally support the exchange of ideas information and personnel at all levels.

Finally our internal and external efforts, are being progressively co-ordinated and monitored by our Narcotics Commission, the computerised registry of which, will this year begin to feed out valuable data, which will enable us to formulate our overall policies, and to target our various programmes, with increased efficiency. We regard narcotics addiction as a disaster, not only to the individual and his family but also at community level, and we fully support severe punitive measures taken against those convicted of exploiting their fellow men in this way. To those who have

*The current retail price of No. 3 Heroin is about HKk 96,000 per kilo, as compared with HK 53,000 three years ago.

been ensnared in addiction, our attitude is both sympathetic and humanistic, and our aim is to extend to these members of our community, as wide a range of modalities of treatment as we can reasonably manage, to meet differing needs and differing conditions. In this respect our prime objective is to reduce or abolish the individual need for (illicit) narcotics for as long as possible.

For those who voluntarily come forward for relief from their drug dependence we have provided both residential and out-patient facilities. Residential treatment and rehabilitation for both male and female addicts is provided by the Society for the Aid and Rehabilitation of Drug Addicts (SARDA), whose facilities are made available to all for as long and as often as they are required. Outpatient facilities are provided by the Medical and Health Department through an extensive system of clinics, strategically situated throughout the region providing methadone maintenance and/or detoxification. For convicted offenders we have a renowned service of treatment and rehabilitation operated by the Prisons Department in their Drug Addiction Treatment Centres. Finally, we have a pilot project nearing completion which is studying the feasibility of providing and additional service to out-patient addicts using acupuncture to suppress detoxification symptoms and to allay subsequent cravings. I would like to elaborate briefly upon these various programmes which we now have in operation.

Outpatient Methadone Maintenance and/or Detoxification

For those drug dependents who prefer out-patient as opposed to residential treatment a programme of methadone maintenance and/or detoxification is provided under the supervision of the Medical and Health Department. The maintenance programme began in 1972 and has 4 clinics subsequently. The detoxification programme was commenced in 1976 with the opening of 12 centres throughout the territory, expanded last year, to 17. Two of these centres are open throughout the day, whereas the remaining 15 centres are open in the evenings, since experience has shown us that the majority of addicts prefer to come for their daily doses of methadone after working hours. The centres are each manned by a doctor, a social worker and auxiliary medical personnel who register the patients and dispense the treatment; they accept both male and female patients over the age of 18 who have addiction histories of two or more years. Those who are under the age of 18 and have addiction histories of less than two years are referred to SARDA for residential treatment and rehabilitation.

Whereas the Methadone Maintenance Programme is aimed at providing the addict with a substitute for his heroin or opium for an indefinite period of time, methadone detoxification is aimed at gradually weaning the addict off drugs over a period of six to eight weeks by gradually decreasing the daily methadone intake. The Medical Department has however, wisely adopted a pragmatic approach in respect of these two programmes, permitting some patients to attend at the detoxification centres long after the normal period of detoxification has passed, whilst

similarly detoxifying patients on maintenance, at their request. There are in addition, formal transfers between the two types of centres. The over-riding aim of course, is to encourage the addict to continue treatment for as long as his individual circumstances deem it to be necessary. The number of persons currently registered with the outpatient detoxification and maintenance programmes is presently in the region of 7637, with an average attendance of 5300 per day.

Acupuncture and Electro-Stimulation

A study is being made at present, under the supervision of a distinguished Neurosurgeon in Hong Kong, into the feasibility of using acupuncture and electro-stimulation (A.E.S.), as a method of dealing with detoxification and subsequent craving for narcotics. We are awaiting the final report on these investigations at the end of next month and there would appear to be strong indications that these methods will provide us with yet another useful modality of treatment. In further research, using A. E. S. combined with naloxone, addicts have been completely withdrawn from drugs in $3\frac{1}{2}$ hours.

Compulsory Treatment and Rehabilitation

Some 20 years ago in 1958, Hong Kong commenced compulsory treatment for drug addicts with the opening of the Tai Lam Prison, now known as the Tai Lam Addiction Treatment Centre, where convicted prisoners who were found to be drug dependent and who had sentences of three years or less, were given specialised treatment and rehabilitation. In 1969, the Government introduced an ordinance empowering the courts to commit a person who had been convicted of an offence punishable by imprisonment to be sent to a custodial treatment centre for 6 to 18 months (now changed to 4 to 12 months), the actual date of discharge being determined by the prisoner's health and progress during that period, together with an assessment of the likelihood of his continuing abstinence following release.

Provision was also made for one year's statutory after care following that release, during which the addict could be recalled for further treatment if necessary. Considerable expansion of these facilities has been carried out in the years since 1958, and the Prisons Department is now operating three such centres for male addicts, with a section of the Tai Lam Centre being set aside for the treatment of female addicts who have been convicted of imprisonable offences.

Shortly following his admission to the centre, the addict begins to receive counselling from his after care officer, with particular stress being laid upon the re-establishment of fragmented family relationships. Prior to release, arrangements are made for lodgings and employment, and for those who have no such accommodation, there are the facilities of the Department's Half Way House, where residents engage in normal employment during the day but are required to return to the house in the evening. In addition there are two clubs providing recreational amenities

and social activities for those released from the Prison Treatment Centres. These clubs are operated by an independent agency working in close co-operation with the Prisons Department. The number of people who are undergoing compulsory treatment and after-care at the present time is in the region of 1530 and 2370 respectively.

Voluntary Residential Treatment and Rehabilitation

In 1960 the Society for the Aid and Rehabilitation of Drug Addicts (SARDA) was formed, the aim being to provide an inpatient service for those addicts who were anxious to come forward voluntarily to seek treatment for their addiction. In 1963 the Shek Kwu Chau Centre was opened, offering an inpatient service up to six months for those over **the age of 19 and for 12** months for those below that age. The voluntary aspect of the self-commital of an addict to this programme is both respected and emphasised, and with counselling and due consideration a resident determines his own length of stay; furthermore, if and when he becomes readdicted following discharge from the centre, he may apply for readmission to the programme. During his stay in the centre, medical and counselling services are provided to effect both physical and psychological rehabilitation, with particular emphasis being placed upon management participation and the development of both personal and community responsibility.

Following his discharge, an after-care service is provided extending for two years from the date of admission. This operates from six regional centres which also provide social facilities for evening activities. The Society also operates two clinics in the urban areas for the pre-admission and post-discharge medical care of SARDA patients.

In addition to the treatment centre for the male addicts at Shek Kwu Chau, SARDA also operates a centre for female addicts which is situated in the urban area of Hong Kong.

All dischargees from the SARDA programme are encouraged to join the ex-addicts Association, which has a large membership and which contributes considerably to the SARDA rehabilitation and after-care programme as well as participating in the anti-narcotic campaigns organised by the Action Committee Against Narcotics (ACAN) which is the sole advisory body to the Hong Kong Government on all narcotics issues.

The number of persons undergoing voluntary treatment, rehabilitation and after-care in the SARDA programme is presently in the region of 468 and 3332 respectively.

Conclusion

In the field of treatment and rehabilitation of narcotics addiction, our experience has clearly shown us that as far as our community is concerned, there is no single approach which has universal applicability. We have found that addiction is no respecter of circumstances, and those have

become addicted vary widely, not only in their needs but also in their responses to different programmes. Our response to this situation has therefore been pragmatic and we have opted decisively for the multi-modality approach to the provision of treatment and rehabilitation facilities.

Success, in parentheses, is a relative and not absolute concept in this context. Its measurement might be gauged by increasing lengths of abstinence, by reduced criminal activity, by rising prices at street level. It might be assessed by stabilising family situations, by massive involvement in treatment programmes or by diminishing numbers of teenage involvement in addiction. Whichever of these indicators are employed, all point to our efforts making significant inroads into this longstanding problem.

With the development of relative prosperity in Hong Kong in recent years the Authorities have made concomitant efforts to improve the quality of life of those at the lower end of the social scale. This also has a close bearing upon the problem of addiction since it is from this section of the community that we find the majority of addicts. Social security has been expanded to provide public assistance benefits and allowances for the elderly and the disabled, again this has particular application in the case of addicts and their families. Likewise the expansion of the housing programme, and the rehousing of addicts and their families in areas where there is reduced contamination. For the youth whom we are so anxious to protect and safeguard, organisations have been established providing facilities for the healthy use of leisure time. On the workshop floor, provision has been made for statutory holidays, sickness allowance and increased protection against accident and dismissal etc. All of which means an improved social setting which not only helps to eliminate the long term causes of addiction in Hong Kong, but also assists positively towards the social rehabilitation of existing addicts. We feel that our efforts have not been in vain and that we are able to say with some confidence that we appear to be containing the situation at this moment and that we have serious grounds for hope that we have at long last reached a turning point in our long history of addiction. May this aspiration be realised, not only for ourselves but also for all our neighbours in South East Asia.

REVIEW OF DRUG DEPENDENCE TREATMENT AND REHABILITATION IN INDONESIA

By

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Trends in the development of the phenomenon of drug abuse

The phenomenon of abuse of dependence-producing drugs in Indonesia, has actually been known long before the Second World War. The Indonesian society was already acquainted with traditional opium smoking especially among the Chinese. They obtained their supply legally up to the end of the war when paragraphs in the Narcotic Law which allowed the use of opium was banned (Brisbane Ordinance) (1).

Unfortunately neither the Dutch Colonial nor the Indonesian Government have since then taken serious steps to follow up this change in the Narcotic Law, due to the fact that more important and pressing problems had to be solved like the struggle for the Independence of Indonesia and post-independence evolved problems. At that time there were no treatment facilities for opium addicts, so that they had to meet their habitual need (addiction) from illegal resources, which in fact might be an important stimulating factors for the establishment of illegal narcotic trafficking. Of course other social, legal and environmental conditions have also played a significant role in the further course of this unlawful deed.

Alcoholic beverages was easily obtainable everywhere even in small villages, and used by adults in a casual and recreational manner. Up till the sixties its use was still limited, but thereafter it became more extended and the number of users was increased. But although the number of users has increased, up till now one will rarely see drunken persons on the street.

During the last decade, in particular since 1969, among young Indonesians in metropolitan cities like Jakarta, it is apparent that abuse of dependence-producing drugs is on the rise. These youngsters were especially from the middle and upper class families, and usually drop-outs from school. Marihuana, also called ganja (which grows wild in Indonesia and in a manner difficult to control) was very popular among them, and cigarette (tobacco) smoking was widespread and they started it at a relative young age.

It is apparent that nowadays tobacco is the most abused drug in Indonesia (current smoker). Besides that the abuse of morphine type drug enter upon the scene. In the following years apparently the victims of marihuana and morphine abuse were increasing. This was proven by the fact that in 1969 only one case was admitted to a private mental hospital for treatment, and in 1971 there were six in the same mental hospital (2).

Besides marihuana and morphine, other drugs like alcohol, barbiturates and certain other drugs with sedative pharmacological effects such as diazepan and methaqualone, started also to be used. Generally they were used concurrently (multiple or poly-drug use), which seems to indicate the presence of certain underlying psychopathology.

Although hallucinogens and amphetamines also began to be abused, but not in such alarming proportions as compared to the use of marihuana, morphine, alcohol, and barbiturates. Up till now we have never discovered a case with cocaine and volatile solvents abuse yet.

Drug abuse is still considered as a major adolescent problem in Indonesia, although hospital admissions have decreased in the last few years. Apparently this is due to the fact that since then the Police has successfully managed to curb the illicit narcotic drug traffic, especially morphine and heroin, and so has substantially reduced its availability. But soon afterwards it was noted that the "moderate" use of alcoholic beverages by adolescents who were previously abusing morphine or heroin, became "immoderate" certainly to the point of a state of intoxication (drunkeness). The same pattern also happened with the abuse of drugs of the barbiturate type. It seems that the trend is still towards poly-drug or multiple drug use, especially the sequential substitution of one drug for another when a preferred drug is not available.

Regarding the Police efforts in curbing the illicit narcotic drug traffic, it is necessary to note that during the last few months illicit narcotic drugs are available again at the same place and areas, but not as much as before. This fact is supported by the increase of treatment admissions for drug dependence of the morphine type.

Early treatment facilities

Since 1969 state and private mental hospitals in Jakarta have begun to admit teen-aged youngsters wanting to get rid of their drug-taking habit of the morphine and marihuana type. They were the first group of Indonesian youngsters receiving medical and psychiatric treatment which consisted of a detoxification regiment and preliminary rehabilitation.

On an out-patient or ambulatory basic a substantial number of drug dependents were treated for detoxification and follow-up treatment of underlying conditions. A substantial number too were put for safe keeping" by their parents to the police, especially to the Section of Child, Youth and Women Activities, where "cold turkey" of "shock" treatment for detoxification is considered as the right and best treatment modality for drug

dependents by assuming that they will be affraid of taking drugs again by suffering intense pain. This procedure is followed by preliminary rehabilitation activities.

It is worthwhile to note here that in Indonesia the Police and psychiatrists were considered by the public as the "first-line professionals" dealing with drug dependents, apparently conscious or unconscious motives regarding them as delinquents or as mentally sick, thus needs punishment or treatment. We have also the impression that a substantial number of drug dependents too were brought by their parents to traditional and faith healers, most often without their consent or even their knowledge.

Further development of treatment and rehabilitation facilities

To overcome the increasing drug abuse problem especially among the Indonesian youths, the local government of Jakarta established a body which cooperates and coordinates health, social, educational, law-enforcement and other agencies to deal with the problem and to set up a treatment centre especially for the victims of the problem. The local coordinating body was recognized since November 1971, but the treatment centre has been in operation since the 3rd of July 1972 under the name Drug Dependence Unit (3).

A further description of this treatment centre is needed, since this treatment centre seems to be the treatment prototype for other existing treatment and rehabilitation centres afterwards run by the Police and the Ministry of Social Welfare.

The Drug Dependence Unit

This centre is situated in the complex buildings of the Fatmawati Hospital, Cilandak - Jakarta, located at the southern outskirts of the city. It occupies a newly built building which was initially designed and built for the psychiatric ward of this hospital, and has a maximum capacity of 30 beds.

Its treatment program consists of five stages :

a. Information to the patient and parent
b. Physical and psychiatric examination
c. Detoxification and treatment of medical complications
d. Post-withdrawal treatment
e. Procedure for patient discharge.

Information to the patient and parent

This first stage is very important and needed, particularly for non-compulsory treatment. Evaluation and assessment of the pattern of drug use, the state and condition of dependency, the awareness of his sickness, and his motivation for treatment can be implied at this stage. Preliminary planned activities after his discharge should be discussed among the patient,

the parent and the physician. The absence of a long-range contingency after-treatment plan or activities will cause the patient inevitably to return to the previous condition, and the relapse will be greater and accelerated.

Difficulties are encountered whenever the patient did not have motivation to be treated while the parent insisted upon compulsory treatment. Explanation given to the parent about the uselessness, the difficulties that will arise from compulsory treatment, and the suggestion for a temporary ambulatory treatment are frequently unacceptable for the parents. Another difficulty also arise when the drug abuser is still in their experimental or casual phase of drug use, and the parents insisted for residential or in-patient treatment and undergo a detoxification.

Physical and psychiatric examination

After providing information to the patient and the parent, and the patient is willing to undergo treatment, physical and psychiatric examination will follow. The purpose of the examination is to determine the physical and mental condition, presence of any other disease or medical complication due to the use of drugs such as hepatitics, infections, and so on. As it was expected a substantial number suffered various medical complications, concomitant diseases and serious mental disorders.

Detoxification and treatment of medical complications

Drug dependent patient who uses drugs continuously and particularly those that have lasted for a long time, is considered as a patient suffering a chronic intoxication. Basically therefore withdrawal treatment is an effort of detoxification, and by paying sufficient attention to the physical and mental condition of the patient.

Various detoxification procedures ranging from abrupt withdrawal to gradual withdrawal, or abrupt withdrawal supported by symptomatic drug therapy (major or minor tranquilizers, analgesics, antispasmodics, etcetera) were used, depending on the state of dependency, the physical and mental condition of the patient. Accupuncture therapy is carried out but rather inconsistently (4).

Post-withdrawal treatment

Treatment approaches or activities such as individual supportive psychotherapy, individual counselling, group activities, recreational activities, sports for physical fitness and relaxation, language courses and other alternative programmes such as art (handicraft and painting) and musical session, have become part of the basic program during this stage. Some therapeutic activities are individually determined. Psychological testing is carried out to evaluate the basic personality and intellectual potential. Social evaluation is done by social workers.

Family participation programme, either through family therapy or other less structured family involvement is also made use of - Every Saturday, a general open discussion is provided for parents or other family members, and once a week a case conference is held by the psychiatric team.

Procedure for patient discharge

The long-term contingency after-treatment plan suggested in the first stage is discussed together among the patient, parent and psychiatric team more thoroughly and in detail. This after-treatment plan or after-care programme consists of activities such as individual psychotherapy and counselling, family therapy or counselling, social guidance and other social-work-services. Other social activities and community participation programmes are encouraged such like joining the Youth Red Cross, participation in Youth Centres programmes, and other meaningful alternative activities.

The further development of this Drug Dependence Unit as a Institute was established after two years in operation, as on a more idealistic and dynamic basis other important units like Laboratory (Thin-layer chromatography), Day Centre Programme for ex-patients, Central Case Register and programme in Epidemiology has been set up.

Other treatment and rehabilitation facilities

a. As mentioned before, since the beginning of the drug abuse problem the state as well as private mental hospitals have begun to admit drug dependent patients for withdrawal treatment and preliminary rehabilitation. General hospitals were also requested to admit drug abuse patients with acute intoxications for intensive care treatments.

The Directorate of Mental Health, Ministry of Health, with its state mental hospital system was assigned to monitor the drug abuse problem and admit patients to its facilities if they come with problem of drug abuse.

b. **Wisma Khusnul Khotimah**

A Social Rehabilitation Centre located nearby the centre of the city (Jakarta) is operated by the Department of Social Welfare since 1974. Admissions requirements are:

a. those who have been medically treated for physical dependency on drugs
b. age between 14 and 22 years
c. well motivated
d. the family must be prepared to cooperate and assist the implementation of the rehabilitation programmes within as well as outside the Centre.

The rehabilitation programme consists of :

a. Intake process administered by social workers (a study report on the social conditions), by physicians (medical examination), and by psychologists (collecting psychological data).

b. Case Conferences by the rehabilitation team to evaluate social rehabilitation activities like diagnosis (identification of social environments and collecting social data, psychological observation, and psychiatric treatment and preparation of psychiatric scheme), mental build-up, ability development, and selecting and defining programmes

c. Placement, Three placement possibilities may be identified for the benefit of clients:

1) residential placement (parental homes; foster parents homes; half-way houses)

2) work opportunity through self-employment, factories/offices/enterprises, and sheltered workshops

3) school education

d. After care. Carried out at set times for a period of time.

c. **Wisma Pamardi Siwi**

A newly established spacious correction centre run by the Police (Child, Youth and Women Section) has been set up with maximum bed capacity of 250 (at present this residential centre can accommodate 102 persons). Admissions are on parental request, and is basically a compulsory treatment approach.

At present the centre has 5 dormitories: 2 dormitories for convicts (women), 1 dormitory for delinquent girls, 1 dormitory for delinquent boys, and 1 dormitory especially for male narcotics addicts.

Maximum length of stay is 5 months.

Detoxification procedure for narcotic addicts is abrupt withdrawal ("cold turkey"), except for those after medical examination considered as "severe case".

Skill training (Sewing, hair dressing, carpentry, photography, and others) is an important part of the rehabilitation approach. Medical check-up, social case study, psychological evaluation, psychiatric evaluation, case conference and re-entry into society are essential parts of the rehabilitation programme.

This centre started its operation from October 1974.

d. **The drug Abuse Centre in Surabaya (East Java)**

Since 1977 the local coordinating body in overcoming the drug abuse problem in East Java has established a drug abuse centre located next to the psychiatric ward of Dr. Sutomo General Hospital in Surabaya. A 15

bed capacity treatment and rehabilitation centre with nearly the same treatment approach and programme as the Drug Dependence Institute in Jakarta.

e. **Santikara**

A private Mental Health Foundation, originally started with the aim of Mental Health Education for the community, has developed other activities in line with the field. With the emergence of the drug abuse problem among the youth, this Foundation also started to deal with this problem. The first approach was done on a non-residential basis (ambulatory treatment), and in November 1974 they started a residential programme located in the mountain resort outside Jakarta.

The approaches used in the residential programme are based on family participation. For a few days, members of the family are encouraged to stay in the centre and become actively involved in the programme. Daily activities such as individual counselling and group activities, mostly under the guidance of social workers.

Unfortunately due to certain circumstances this residential centre stopped their activities after approximately one year in operation.

The adoption by the Parliament of a New Narcotic Law

Like in other countries that have to face an emerging drug abuse problem the existing Narcotics Law was considered as inappropriate to overcome the problem effectively. Also in Indonesia since July 1976 the Parliament has adopted a New Narcotic Law, in which essentially more severe penalties for illicit drug traffickers and a tight control of legal distribution of narcotic drugs especially for medical purposes are stipulated. Regarding the drug abuser or addict in the New Narcotic Law, they are considered as criminal but also regarded for need of treatment and rehabilitation.

Guidelines for Drug Abuse Rehabilitation according to the New Narcotic Law

Based on this new law the Coordinating Minister of National Welfare have appointed a Committee to formulate further implementations more specifically for treatment and rehabilitation of drug dependents. Members of this Committee were officials from Ministries and Agencies of the Indonesian Government. Almost all Ministries and Agencies were involved.

One of the results of rather intensive discussions is a programme outline for Guidelines for Drug Abuse Rehabilitation. This document will form the "basic outline" of drug abuse rehabilitation processes and phases which have to be carried out by a comprehensive rehabilitation programme. Every treatment and rehabilitation unit or agency will be requested to identify more specifically its modality (ies) and direct their programme in the near future to this "basic outline", so that in this way a better coordinative approach can be effected.

The basic assumptions of the treatment and rehabilitation of drug dependents are:

a. a person suffering from a condition of chronic intoxication

b. their physical, mental and socio-cultural conditions have to be improved

c. a long-term follow-up guidance.

In consequence of these basic assumptions, five distinct phases in the treatment and rehabilitation are to be considered, namely:

a. Initial Intake for provisional diagnosis, referrals to adequate treatment service or unit

b. Detoxification and Treatment of Medical Complications

c. Stabilization process for the enhancement of the physical, mental and socio-cultural conditions

d. Preparation for Re-entry into Society

e. Resocialization within the community.

(For details see Appendix)

It is regarded by the Committee that the most important and difficult phase of the rehabilitation of drug dependents is the stabilization process, and it seems that up to now present techniques and approaches are less efficient and difficult to implement at this phase.

It is a fact that no single approach or modality has proved to be universally successful. One modality or approach which seems to be effective for certain drug dependents is not necessary applicable for other drug dependents. The focusing on delineation of realistic goals and increasing the ability to conceptualize the means for achieving a satisfying alternative life-style would be an important component of the therapeutic process for drug dependents.

Conclusion.

In the course of our limited experiences in the field of treatment and rehabilitation of drug dependents, we have come to know that the treatment and rehabilitation of drug dependents is subjected to so many interacting factors, so that a single modality or approach will be unsuccessful and frustrating.

There is no single agency that will be able to provide an effective treatment and rehabilitation programme to drug dependents, the less by one dicipline alone. The multiple poorly understood causative factors, and the realization that the portrait of the drug dependents in terms of his personal and socio-cultural characteristics is not entirely clear, make it important that more work in the treatment and rehabilitation of drug dependents must be done. It is our opinion that even the procedures and techniques for the first two phases (initial intake and detoxification) that are generally considered to be effective, must be further improved. The more will be for the other following phases, especially the stabilization phase or process.

It is for this reason that we deemed it a great opportunity and honour to be able to attend this important seminar, jointly organized by the Government of Malaysia, the United Nations Division of Narcotics Drugs, World Health Organization, the International Council on Alcohol and Addictions, and the Colombo Plan Bureau, and we believe that all of us here will certainly attain more information from each other, and learn more from the experiences in the field of treatment and rehabilitation of drug dependents in South East Asian Countries.

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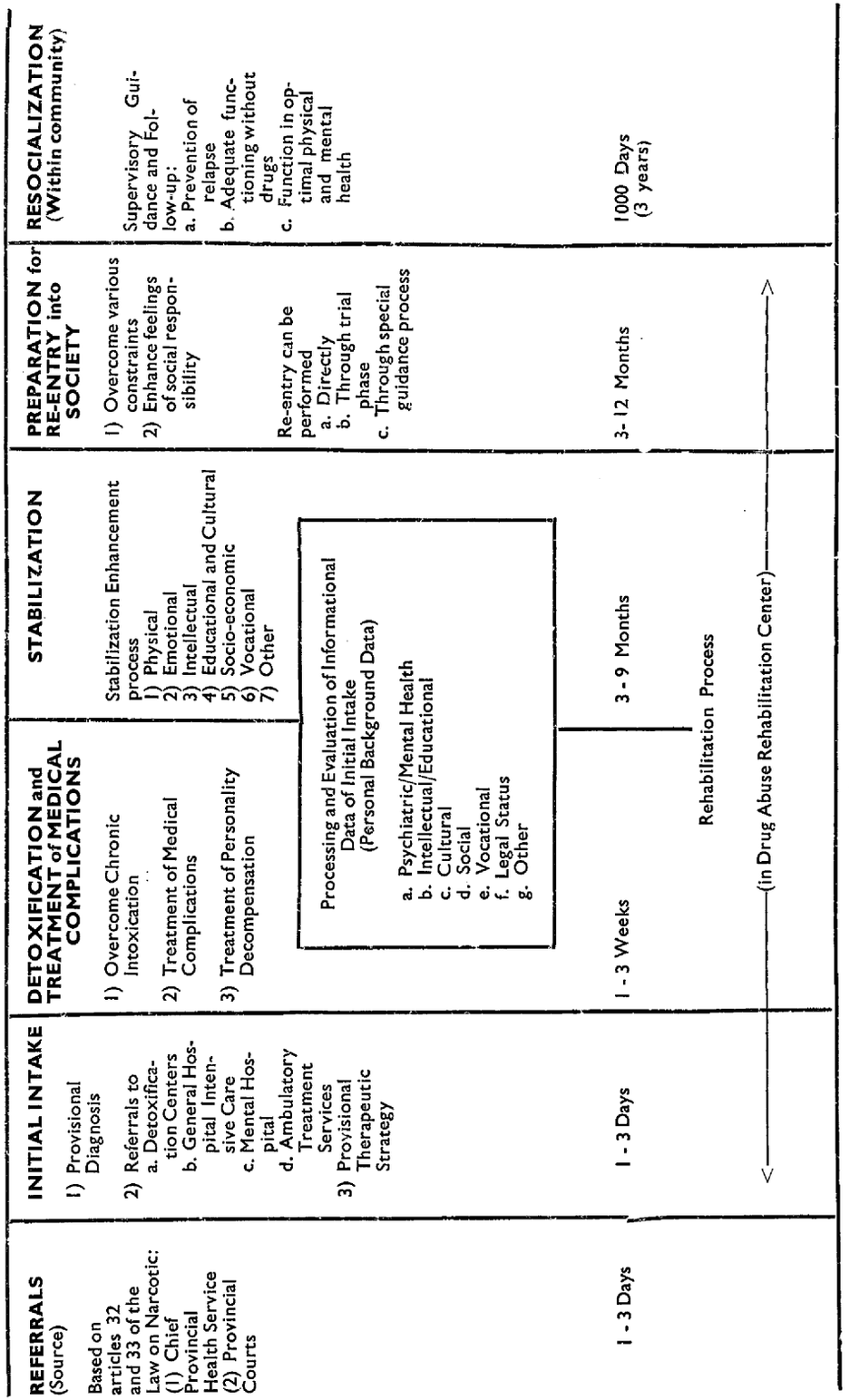
General Guidelines for Drug Abuse Rehabilitation



General Guidelines for Drug Abuse Rehabilitation

I. Initial intake

a) Basic Policy

Referrals of drug abuse 'victim' (drug abusers) are received through two channels :

(i) Chief, Provincial Health Service
(ii) Provincial Courts

and are based on articles 32 and 33 of the Law on Narcotics.

b) Objectives

1. To establish a provisional diagnosis encompassing such data as
   personal medical history
   patterns of drug use: experimental, casual or recreational, situational, intensified, compulsive dependent.
   level of dependence (on drugs)
   medical complications
   general physical condition
   mental health condition
2. To decide on the most adequate referral
3. To decide on the (provisional) therapeutic strategy, emergency therapy, etc.

c) Course of Action

1. Special Interview technique
   Personal Data and History of Drug Use
3. Clinical and Physical Diagnostic procedures :
   a) vital signs/symptoms
   b) skin
   c) eyes
   d) pupil
   e) nose
   f) chest
   g) abdomen
   h) central nervous system
   i) motoric functions
   j) pathologic reflexes
   k) brief psychiatric examination
4. Laboratory examinations/test
5. Thin-layer chromatography
6. If necessary also : EEG, ECG, and other examinations

d) Personnel

1. Doctors and nurses with special training in drug abuse treatment and rehabilitation
2. Laboratory technicians
3. Administrative personnel

e) Other

Based on the provisional diagnosis the drug abuser is now referred to the next phase of rehabilitation process, the Detoxification and Treatment Facility for Medical Complications. Or he may be referred to one of the following facilities :

a) the General Hospital, Intensive Care Unit
b) the Mental Hospital for treatment of an underlying psychiatric condition
c) to an Ambulatory Treatment Facility which is authorized to carry out this type of treatments

II. Detoxification and Treatment of Medical Complications

a) Basic Policy

1. A drug abuser, especially a narcotic drug dependent, is a patient suffering from a condition of chronic intoxication. For this reason the first phase of treatment should be to withdraw the intoxicating compound from his physical system.
2. A drug abuser rather frequently suffers from medical complications and these should receive proper medical attention.
3. The withdrawal treatment is not without risk, especially if the patient abuses a number of drugs combined such as narcotic drugs, alcohol and barbiturates. There are instances that such conditions can be very severe and even have fatal consequences.
4. If withdrawal is done at once (abrupt withdrawal) a frequent mental condition can emerge, the so-called personality decompensation syndrome, in which the patient suffers from intense confusion and even massive painful sensations. A medical clinical examination is therefore an absolute necessity during withdrawal treatment.

b) Objectives

1. To withdraw ("to free") the abuser from a chronic intoxication (opiates, barbiturates, alcohol etc.)
2. To give proper attention to possible medical complications
3. To avoid "personality decompensation"

c) **Course of Action**

1. Continuous 24-hours observation of patient's physical and mental condition

2. Monitor all modalities used in the withdrawal treatment (abrupt withdrawal, symptomatic treatment, substitution therapy, accupuncture, and other)

3. Treatment of emergency conditions

4. Avoid personality decompensation and adequate treatment for this condition if such occurs.

5. Treatment for medical complications

d) **Personnel**

1. Medical doctors and nurses with special training
2. Medical specialists for purposes of consultation
3. Laboratory technicians and paramedical personnel

e) **Other**

1. Based on medical principles certain conditions must be fulfilled in this area of medical care

   (i) the facility should be a special section of an existing hospital or a special drug abuse hospital

   (ii) medical instruments and medicines necessary for the treatment of emergency conditions should be available

   (iii) medical instruments and medicines necessary to treat medical complications should be available

2. As soon as the general health condition of the patient has sufficiently improved (physically and mentally) further processing of the intake procedure can be carried out. Data should be compiled on areas of his mental and emotional background, vocational skill, intelligence and education, legal status, etc.

The main objective of the processing of the intake procedure is to establish a comprehensive diagnosis. If time does not allow a complete work up, this can be further carried out during the next phase of the rehabilitation process, the phase of stabilization.

III. Stabilization

a) **Basic Policy**

1. The drug abuser (narcotic dependent) is an individual who because of continuous use of the drug(s) has developed a physical and psychic dependence on the drug(s).

2. Some direct unfavourable effects of this condition are:

   (i) the general lowering of the condition of his health, physically and mentally;

   (ii) failures in adjustment at a family level (in his home), socially and professionally
   (iii) economic and financial dependence
   (iv) tendencies to commit unlawful acts or crimes and if overdosage is the basic condition even sudden death.

3. Some of the known reasons to use drugs (narcotics) are:

   (i) feelings of alienation
   (ii) pain and feelings of discomfort
   (iii) frustration and feelings of inadequacy
   (iv) intense difficulties in work or academic performance
   (v) anxiety and depression
   (vi) feelings of being discriminated

4. The drug abuser some times feels that he can perform or function better when he is taking drugs, but this is usually a very subjective statement.

5. The stabilization phase aims achieving a better general level of physical and mental well being.

6. Social stabilization covers goals which are directed to the enhancement of social responsibility feelings for the drug abuser under treatment and his family as well so that it can be considered as a "social group process".

7. Cultural and educational stabilization mechanisms aim at the enhancement of the level of general knowledge, general skills and aesthetic feelings.

8. The stabilization of skills aim at developing flexibility and dexterity in carrying out household skills, adapting and adjusting to changing environments and willingness to work.

9. Stabilization of religious feelings aim at enhancing religious practices and religious harmony (understanding of other religions than his own)

b) **Objectives**

To achieve stabilization in the areas of health, intellectual performance, emotion, education and culture, religious feelings, social adjustment and general skills in order that the adolescent drug abuser after his rehabilitation can function better and more meaningfully without the necessity to use drugs.

c) **Course of action**

1. **Religious stabilization:**

   a. to be more conscious about the place of man within the framework of nature and universe
   b. to understand human weaknesses
   c. to understand the meaning of religion to man
   d. to stimulate feelings of optimism based on religion
   e. to engage in religious practices (pray, group reading of religions, etc)

2. **Stabilization of physical health**

   a. Diagnostic Classification and evaluation of the individual's physical health condition
   b. symptomatic therapy
   c. physical therapy
   d. relaxation exercises

3. **Stabilization of mental health level**

   a. Diagnostic classification or evaluation of mental health status
   b. individual and group psychotherapy
   c. psychotropic medication
   d. medication to enhance cerebral metabolism or stimulative to central nervous system
   e. family therapy
   f. alternative approaches

4. **Social stabilization**

   a. Individual/social case work activities
   b. social group work activities
   c. family case work activities
   d. community guidance at the abuser's residence or residential area.
   e. continuous information session for special groups of clients as well as for people associated with such clients

5. **Stabilization in the areas of education and culture.**

   To maintain and improve the level of general knowledge and skill adapted to his level prior to entering the rehabilitation process.

   Activities can be done in a number of ways :

   a) individual or group instruction
   b) evaluation studies of achieved results

   c) special instruction classes for those who are relatively slow learners
   d) special instruction classes for those who wish to learn special skills
   e) special classes to enhance aesthetic feelings in the fields of poetry, writing, dancing, etc.

6. **Stabilization of (Vocational) Skills.**

   a) to establish to the individual capacity to acquire vocational skills
   b) apititude testing
   c) to overcome barriers or constraints in placement of the individual
   d) to enhance or improve the individual's skills
   e) training of new skills

7. **Other stabilization mechanisms as needed individually**

d) **Personnel**

1. **Religious stabilization**

   a) Religious leaders who are interested in problems of adolescence
   b) Religious leaders knowledgeable about the developmental problems of adolescent drug abusers and willing to associate with them

2. **Physical stabilization**

   a) medical doctors and nurses with special training
   b) accupuncturist
   c) sport leaders/specialist in physical education
   d) other supportive specialists
   e) information and education specialists

3. **Mental health stabilization**

   a) medical doctors and nurses who were adequately trained
   b) ex drug abusers who successfully terminated the rehabilitation programme with additional training in mental health
   c) other specialists with special knowledge in the area of "alternative approaches" or "meaningful alternatives',

4. **Social stabilization.**

   Social workers with special training in drug abuse rehabilitation

5. **Stabilization in the areas of Education and Culture**

   a) Educators/Teachers on special subjects
   b) Other educational specialists

6. **Stabilization of (Vocational) Skills**

a) Special placement officers
b) Vocational guidance officers
c) Vocational training instructors

7. **Other Stabilization procedures**

Specialist personnel as needed

e. **Other.**

This phase is difficult a phase with many complicating factors and no 'standard' approach seems to be possible. Emphasis is laid on efforts of integration and cooperation of all professionals and professional institutions active in this field.

IV. Preparation for re-entry into society

a) Basic Policy

1. Those drug abusers who successfully terminated the previous phases (detoxification, therapy of medical complications and stabilization) can **directly** perform this 're-entry into society' successfully if their parents and their community can accept them back in a positive way.

2. However, a fairly large segment of drug abusers (although having finished the previous phases successfully) appear to have difficulties in this phase of 're-entry into society'. Most difficulties are associated with their own personality, habits, family members and community where they live.
These adolescents need a special preparatory programme before their 're-entry into society' can be performed reasonably successfully:
a) via (through) a trial phase
b) via (through) a special guidance programme

3. If 're-entry' is to be performed through a 'trial phase' a number of special activities are to be performed during the stabilization phase. These activities have limited goals and specifically directed.

4. In case 're-entry' is to be performed through a special guidance programme, certain (vocational) skills will be studied.

A number of problems will be approached: economic or financial difficulties, problems in the areas of social adjustment, cultural adaptation, and other.

b) Objectives

To enhance feelings of social responsibility towards society at large, his own direct community and his family.

c) Course of Action

1. Preparation for direct 're-entry into society' involves a number of special arrangements:

to prepare this 're-entry' in cooperation with his family, his direct community as well as with the adolescent himself with regard to challenges which will be faced in reality; to plan further consultations with the appropriate agency or counsellor with regard to problems which may arise not only in the area of concrete difficulties but also in the 'spiritual sense' (e.g. social responsibilities towards his country's philosophy Pancasila, etc.)

2. Preparation for 're-entry' through special programmes :

(i) Day Centres
(ii) Night Hospitals
(iii) Trial discharges

With certain activities of a more limited nature as compared to these during the stabilization phase.

3. Preparation for 're-entry' through a special guidance programme which eg. contains the following:

(i) problem solving of economic and financial difficulties
(ii) difficulties of re-acceptance by family or community
(iii) overcome difficulties of personal nature: disgrace, lack of self confidence, etc.
(iv) difficulties at school, job placement, and other socio-cultural difficulties.

d. Personnel

1. Re-entry into society in a direct way will follow the general pattern as described for the stabilization phase
2. Preparation through special programme in Day Centres, Night Hospitals and Trial Discharges will need the same personnel as for the stabilization phase
3. Preparation through special guidance programmes will need personnel who have been trained as social worker with special abilities with regard to guidance of adolescents.

e. Other

As needed.

V. Resocialization (in Society)

a) Basic Policy

The drug abuser should be able to conduct a meaningful life (with due regard to the limitations that are set by the realistic situation) and utilizing the "societial infrastructures', which are existent and stable institutions like school, "persantren', (religious boarding schools), job offered by employers, and other agencies.

b) **Objectives**

It is a reasonable expectation that those who completed the previous phases successfully will be able to establish themselves in society in a more stable way without the necessity of using drugs. If however a relapse would occur they would be able to benefit from earlier experiences so that they would be in better control of their behaviour

c) **Course of activities**

Long term follow up guidance by

1. family members (especially parents)
2. teachers
3. social workers
4. special placement officers
5. medical doctors and psychiatrists
6. nurses
7. other concerned individuals

d) **Other**

Follow up guidance should be done continuously over a period of "one thousand days'' (about 3 years time)

OVERVIEW OF TREATMENT SERVICES OFFERED TO DRUG USERS IN THE PHILIPPINES

By

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I. INTRODUCTION:

On March 30, 1972, His Excellency, President Ferdinand E. Marcos recognizing the deleterious effects of drug abuse on the health and well-being of the Filipino youth and the threat that it poses to national security, signed into law, Re. Act No. 6425, otherwise known as the Dangerous Drugs Act of 1972. This law placed under control not only narcotic drugs but also psychotropic substances. Immediately after the declaration of Martial Law, on September 21, 1972, President Marcos ordered the Secretary of National Defence (Gen. Order 2-A, September 22, 1972) to arrest or caused the arrest, take into custody and hold all persons who have committed violations of the Dangerous Drugs Act until otherwise released by him or his duly designated representatives.

The imposition of Martial Law in the Philippines in September, 1972 hastened the seizure of two heroin manufacturing laboratories and 53 kilos of heroin and the arrest and conviction of three heroin manufacturers and five accomplices. This generated favourable effects on the drug abuse situation in the Republic: resulted in the disruption of the heroin trade, and created a more favourable social and moral climate for drug abuse control programme.

On January 7, 1973, the President of the Philippines underscored the need for a more intensive and relentless campaign against the traffic and consumption of dangerous drugs. He declared in a nationwide address over the radio and television: "Because of the manipulation of drug manufacturers, procurers and pushers who victimize even innocent children, I order the military and the police to wage a saturation drive against manufacturers, procurers and pushers of illegal drugs as well as drug addicts, until the traffic and consumption of dangerous drugs is eliminated, or at least reduced to insignificance. The government will give adequate care to the unfortunate victims by appropriating whatever money and services are required for their rehabilitation, but it will severely penalize drug pushers and procurers, and sentence to death any convicted manufacturer."

The Philippine Government has consistently manifested that there is an immediate need for closer international and regional cooperation in the control and prevention of drug abuse. President Marcos emphasized this policy during the 3rd United Nations meeting of Operational Heads of Narcotics Law Enforcement agencies in the Far East Region held in Manila on November 18, 1976. He said: "In the Philippines, I would like to reiterate

the policy of my administration and the policy of our Government. We shall never permit the flow through the Philippines nor the distribution within the country nor the tolerance of the illicit handling, possession, manufacture, release and use of drugs."

A. The Dangerous Drugs Board

On November 14, 1972, the Dangerous Drugs Board was organized to provide leadership, direction and coordination in the effective implementation of R. A. 6425, otherwise known as the Dangerous Drugs Act of 1972. The Board is also the special administrative body implementing the 1971 Convention on Psychotrophic Substances. Consistent with the growing regional cooperation on drug abuse prevention and control, the Board serves as the clearing house of ASEAN member countries on all matters pertaining to law enforcement, treatment and rehabilitation, education, training and research as it relates to narcotics and drug abuse control. It has provided leadership in the promotion of inter-agency coordination, multi-disciplinary cooperation and community participation in the nationwide effort to deal with drug abuse and other related problems. It has also provided technical and financial assistance in the development and implementation of projects to effectively attain the objectives of the drug control programme in the Philippines.

Presently, the Board is composed of six-ex-officio members representing the major departments of the government. The Secretary of Health is the Chairman while the Secretary of the Department of Social Services and Development, Department of Justice, Department of National Defence, Department of Education and Culture, and the Department of Finance or their duly authorized representatives, serve as ex-officio members. The Director of the National Bureau of Investigation is the Permanent Consultant.

Directly under the Board is the Office of the Executive Director which handles all administrative affairs of the Board, and coordinates the activities of the technical staff, which is composed of four major substantive divisions, the Treatment and Rehabilitation Division; Preventive Education and Community Information Division; Control, Regulation and Enforcement Division and Research Statistics and Training Division. These technical arms of the Board assist in the development of policies and programmes designed to weld together the following efforts:

1. Control of supply of drugs through -
   a. coordination of law enforcement efforts
   b. prevention of diversion of dangerous drugs to the illegal market
   c. control of illegal traffic.

2. Reduction of demand for drugs through -
   a. integration of drug abuse prevention education concepts in health and social action programmes for youth, parents teachers, and community (barangay) * leaders.
   b. provision of positive and wholesome activities for young people as alternatives to drugs.
   c. integration of drug abuse prevention in the school curricula.
   d. effective use of mass media through positive developmental communications.
   e. extension of guidance and counselling services to drug experimenters and casual users.
   f. provision of treatment and rehabilitation services to drug dependents.
   g. follow-up and after care services to clients released from the rehabilitation centre.
   h. development of a cadre of trained personnel to undertake the above-mentioned programmes.
   i. establishment of a data bank pertaining to the problem of drug abuse including the maintenance of a central case registry.
   j. establishment of linkage and maintenance of mutual cooperation with regional and international bodies, such as the ASEAN, Colombo Plan Bureau, ICAA, Interpol, Unesco.

II. CURRENT DRUG SITUATION:

In 1972, during the pre-martial law period, it was estimated that there were about 10,000 Filipino heroin dependents. Today, there is no heroin addiction among Filippinos.

The year 1977 continued to bring in favourable developments in drug abuse prevention and control due to such factors as a stabilized socio-cultural milieu brought about by Martial Law and also by long-range education, law enforcement and other regulatory programmes implemented by various government agencies under the coordination and supervision of the Dangerous Drugs Board.

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* The smallest political unit in the Philippines

There were 830 admissions in the five (5) Treatment and Rehabilitation Centres during CY 1977. Filipino drug abusers commonly abuse more than one drug otherwise known as poly-drug abuse. Drugs listed in the order of frequency of abuse by those admitted in the rehabilitation centres are: Cough Syrups and Marijuana, minor tranquilizers, analgesics and barbiturates.

Metro Manila area remains as the principal problem area, although cases are being reported in the urban areas of Visayas and Mindanao. More raids/arrests and seizures were made in 1977 than in 1976 (827 versus 304). Less prohibited drugs of foreign origin were seized in 1977 than in 1976. More Marijuana Plantations/Cultivations were detected and destroyed in 1977 than in 1976.

In general, intensified narcotics law-enforcement had blocked the flow of huge quantities of drugs from reaching the illicit market, thereby limiting the "pushing" and abuse of these drugs. There is no resurgence of drug addiction. Nevertheless, abuse of non-addicting pharmaceutical drugs, glue sniffing and also abuse of a local herb (Talampunay) * continue to compound the problem.

Drug dependency in our country is primarily a problem which affects our youth, predominantly unmarried males whose ages range from 16-20 years.

Furthermore, the drug problem has permeated all ethnic and socio-economic groups, both urban and rural, and the vulnerable targets are those of the lowest socio-economic group and the students in urban areas.

III. LEGAL PROVISIONS FOR THE TREATMENT AND REHABILITATION OF DRUG DEPENDENTS

R. A. 6425 otherwise known as the Dangerous Drugs Act of 1972 provides for the voluntary and compulsory treatment and rehabilitation of drug dependents, as specified in "SEC. 30 - Voluntary Submission of a Drug Dependent to Confinement, Treatment and Rehabilitation by the Drug Dependent Himself or through his Parent, Guardian or Relative." If a drug dependent voluntarily submits himself for confinement, treatment and rehabilitation in a centre and complies with such conditions thereof as the Board may, by rules and regulations, prescribe he shall not be criminally liable for any violation of Section 8, Article II and Section 16, Article III of this Act.

The above exemption shall be extended to a minor who may be committed for treatment and rehabilitation in a centre upon sworn petition of his parent, guardian or relative within the fourth civil degree of consanguinity or affinity, or of the Director of Health or the Secretary of the Department of Social Welfare, in that Order. Such petition may be filed

* Talampunay belongs to Genyus Datura Linnaeus known as Datura Metal Linn. Its active ingredients are scopolamine, hyoscyamine and atropine.

with the Court of First Instance, Juvenile and Domestic Relations Court or Circuit Criminal Court of the province or city where the minor resides and shall set forth therein his name and address and the facts relating to his dependency: Provided that any of said courts shall have jurisdiction to act on the petition for hearing and give the drug dependent concerned an opportunity to be heard. If after such hearing, the facts so warrant in its judgment, the court shall order the drug dependent to be examined by two physicians accredited by the Board. If both physicians conclude, after examination, that the minor is not a drug dependent, the court shall enter an order discharging him. If either physician finds him to be a dependent, the court shall conduct a hearing and consider all relevant evidence which may be offered. If the court makes a finding of drug dependency, it shall issue an order for his commitment to a centre designated by the court for treatment and rehabilitation under the supervision of the Board.

When in the opinion of the person committed or of his parent, guardian or relative, or of the Board, such person is rehabilitated, any of the above parties may file a sworn petition for his release with the court which ordered the commitment. If, after due hearing, the court finds the petition to be well-founded, it shall forthwith order the release of the person so committed.

Should the drug dependent, having voluntarily submitted himself to confinement, treatment and rehabilitation in, or having been committed to a centre upon petition of the proper party, escape therefrom, he may re-submit himself for confinement within one week from the date of his escape, or his parent, guardian or relative may, within the same period, surrender him for recommitment. If, however, the drug dependent does not resubmit himself for confinement or he is not surrendered for recommitment, as the case may be, the Board may file a sworn petition for his recommitment. If, subsequent to such recommitment, he should escape again, he shall no longer be exempt from criminal liability for use or possession of any dangerous drugs.

The judicial and medical records pertaining to any drug dependent's confinement under this Section shall be **confidential and shall not be used against him for any purpose except to determine how many times he shall have voluntarily submitted himself to confinement, treatment and rehabilitation or been committed to a centre.** (As amended by Section 1 of the Presidential Decree No. 44, dated November 9, 1972).

Sec. 31. Compulsory Submission of a Drug Dependent to Treatment and Rehabilitation - if a person charged with an offence is found by the fiscal or by the court, at any stage of the proceedings, to be a drug dependent, the fiscal or the court, as the case may be, shall suspend further proceedings and transmit copies of the record of the case to the Board.

In the event, the Board determines, after medical examination, that public interest requires that such drug dependent be committed to a centre for treatment and rehabilitation it shall file a petition for his commitment with the Court of First Instance, Juvenile and Domestic Court, or Circuit Criminal Court of the province or city where he is being investigated or tried: Provided, that any of said courts may take cognizance of such petition regardless of the age of the drug dependent: Provided, further that where a criminal case is pending in court such petition shall be filed in the said court. The court shall take judicial notice of the prior proceedings in the case and shall proceed to hear the petition. If the court finds him to be a drug dependent, it shall order his commitment to a centre for treatment and rehabilitation. The head of said centre shall submit to the court every four months, or as often as the court require a written report on the progress of the treatment. If the dependent is rehabilitated, as certified by the centre and the Board, he shall be returned to the court which committed him, for his discharge therefrom.

Thereafter, his prosecution for any offence punishable by law shall be instituted or shall continue, as the case may be. In case of conviction, the judgment shall indicate whether the full or partial period of his prior detention and of his confinement for treatment and rehabilitation shall be deducted from the period of the penalty imposed on him, taking into account his good behaviour or misconduct while being detained or confined.

The period of prescription of the offence charged shall not run during the time that the respondent or the accused is under detention or confinement in a centre. (as amended by Section 2 of Presidential Decree No. 44, dated November 9, 1972).

IV. RESPONSE

A. Central Screening and Referral Unit:

In August, 1975, the Treatment and Rehabilitation Division (TRD) of the Board has estabished a Central Screening and Referral Unit, as the TRD staff has experienced that some treatment and rehabilitation centres admit cases without proper evaluation. Likewise, some courts commit cases to rehabilitation centres without subjecting clients to examinations by accredited physicians. As a result, rehabilitation centres admit not only drug dependents but also drug experimenters, casual users, alcoholics, psychotics, depressed clients, clients with behavioural problem and life-stylers. In order to prevent admission of non-drug dependents in the centre and at the same time confine drug dependents in centres whose programme will adequately fill client's needs, the CSR Unit was established and put into operation.

A laboratory solely used for examination of seized drugs and determination of drugs in the body fluids was also established by the Board to complement the clinical team.

B. Facilities for Residential Treatment and Rehabilitation

In 1965, the National Bureau of Investigation (NBI) Treatment and Rehabilitation Centre for Drug Dependents was established in the Philippines. When the Dangerous Drugs Board was organised in 1972, it has set accreditation standards for establishing rehabilitation centres and has also encouraged organisations/ foundations to establish centres for drug dependents. At present, it has accredited 5 major residential centres and out-patient centres. Accredited centres of the Board are also entitled to financial and technical assistance.

The Board has also formulated the National Treatment and Rehabilitation Programme for Drug Dependents whose main objective is to provide an adequate national treatment and rehabilitation services for drug dependents.

The National Treatment and Rehabilitation Programme requires that the effective management of drug dependents necessitates the involvement of teams composed of professionals for we believe that the teamwork approach provides a well integrated and more comprehensive management of drug dependents.

Despite these, the Board has encouraged other modality experimentation as long as that they conform to existing policies.

The following are the various Treatment and Rehabilitation Centres:

1. The National Bureau of Investigation, Treatment and Rehabilitation Centre (NBI-TRC)

This centre is the only government institution handling treatment and rehabilitation of drug dependents and is fully funded by the Dangerous Drugs Board. Their staff is manned by a multi-disciplinary professional team. The goals of the programme of NBI-TRC are:

1. to motivate the drug dependent for extramural living.
2. to provide for him a re-socialization experience.
3. to provide social and vocational training.

Admission to NBI-TRC is voluntary or referred by the Court through the NBI Central Office, Manila. They must be within 13 to 40 years of age and only males are considered for admission.

The activities at the Centre consists of doing the assigned household chores and gardening in the morning. They also have a weekly group psychotherapeutic session with the

centre's psychiatrist and a monthly family therapy session. Other activities revolve around carpentry work, silk screening, wood lamination and arts, like painting, shingle making and metal etching.

Last school year a pilot built-in schooling programme duly accredited by the Department of Education and Culture for first and second year high school residents was integrated into the total programme.

This was conceived because residents in treatment and rehabilitation centres usually seek early discharge because of their desire to continue their studies. Also the lack of provision for continuing education in the rehabilitation centre for drug dependents has become a restraining factor in encouraging drug dependents to submit for treatment voluntarily. Even parents hesitate to have their children confined when they realize that their children will have to forego formal education for sometime.

This school year, there are plans for the programme to be expanded.

The criteria for discharge from the centre are:

completion of the prescribed period of stay at the centre and being drug-free. The NBI-TRC has no follow-up programme for the discharged clients.

2. The Drug Abuse Rehabilitation Network (DARN):

The Drug Abuse Rehabilitation Network Centre is operated by the Philippine Constabulary Anti-Narcotics Unit (CANU) and is staffed by a multi-disciplinary team of professionals composed of medical officers, social workers, psychologists and nurses.

They operate on the principle that the "drug dependent is a person with unique endowments who deserves understanding and respect"; awareness in religion and family unity are the focal points of emphasis termed as the "Felix Concept" after Col. Bienvenido L. Felix, the Commanding Officer of CANU. This is manifested in graces before and after every meal, saying the angelus and the holy rosary every evening, and meetings with parents.

The activities of DARN is centered on green revolution and fowl raising. In addition, combo instruments are provided for the use of residents. Other residents are assigned to the kitchen to help in the preparation of meals, and setting of tables and dishwashing.

Admissions to DARN are mostly referred by the Central Screening and Referral Unit of the DDB, courts and private citizens. DARN caters both to male and female residents.

Visitors are allowed on Sundays and holidays and on week days-in exceptional cases. Home passes are allowed to residents who have performed well during the preceding months, and in emergency cases. The period of confinement is from 6 months to a year. Discharge depends upon the social worker's recommendation for release and the resident's compliance with requirements for discharge which include six months or more period of confinement, and being drug free during the period of confinement.

3. The Narcotics Foundation of the Philippines, Inc. (NFPI)

The Narcotics Foundation of the Philippines, Inc., a private Centre is known as the "Ang Tahanan Rehabilitation Centre." Admission to this centre is voluntary, preferably those without court cases and limited to males. All admissions, too, should be free from infectious diseases.

The activities at NFPI consist mainly of doing things in their workshop like shellcraft, ceramics and making religious articles like rosaries. There are also bi-weekly sessions with the social worker or psychologist for guidance and counselling and for psychological tests if needed. A group therapy session is also scheduled once a week.

The residents are allowed to visit their homes once a month and in emergency cases with the permission of the centre's technical staff.

4. Drug Abuse Research Foundation (DARF)

Presently, DARF has 5 homes to accommodate its clients and in January this year the Board permitted the operation of another centre under the foundation.

This centre does not have trained professionals to manage and rehabilitate the patients but instead they employ ex-dependents as they subscribe to the Therapeutic Community Approach akin to Synannon and Daytop Village.

All cases admitted to this centre are through the Court. Transfer from one therapeutic community to another is frequent to provide the residents varying exposures to the different phases of their programme.

The objectives of DARF are "to help drug dependent lead a drug free life, and also to help him eliminate his negative traits, to act in a responsible, mature fashion and live as a healthy, productive member of society".

Each resident has a work assignment to do which runs in consonance with his past performance and his level of responsibility. These vary from keeping the quarters and the surroundings clean, cooking activity or/on receptionist, secretary or marketer which may change depending on whether one maintains his sense of responsibility and performs well. For that matter too, a staff member could lose his position if he fumbles and does not perform well.

There are many ways by which the objectives of DARF are met. Generally, discussions on the attitudes and behaviour rule the sessions of the residents and some members of the staff. They come in different names, like morning meetings, confrontation, encounter, seminars and games but they all stress on self-awareness, and positive attitudes towards the programme. A few minutes is spared before and after every meal to "relate". Each resident is to speak his mind out about what he feels and thinks at that particular time.

The types of discharge at DARF are those who have successfully complied with the requirements for discharge. those who have been petitioned by their parents and those with court order or authority.

5. Prevent Drug Abusers (PREDA) or Bukang Liwayway Centre

Bukang Liwayway Centre is located in Upper Kalaklan, Olengapo City which is around 130 km away from Manila. It is headed by an Executive Director who is a Catholic priest, assisted by two full-time regular staff and three trainees-resident staff.

The main feature of the PREDA rehabilitation centre is the Primal Therapy, with the Director as therapist. This is described as subjecting the resident to a state of relaxation and is asked to concentrate on thoughts about his early childhood. He is asked to verbalize/screen his past "hurts" and feelings, this is a series of sessions with the therapist. The objective of Primal Therapy is to achieve a natural, tensionless, anxiety-free state. It breaks down defenses as feelings are poured out from within to the outside; feelings/pains which were controlled by the use of defense mechanisms.

OUT-PATIENT SERVICES

1. Shalom House, Baguio City

Shalom House is an outreach centre which offers drop-in facilities for first offenders whose involvement is with soft drugs. It accepts voluntary clients as well as court referred cases. Its motto is "Build Bridges of Communication to Help Stop Drug Abuse". In addition, the centre entertains over a hundred friends, visitors and volunteers. Shalom House offers continuing services of counselling, recreation and music therapy and rap sessions to drug abusers, drug related cases and their families.

2. Malaya Centre

It is an after-care centre under the Department of Social Services and Development.

It serves primarily the released drug dependents who are from 13 to 35 years of age. Potential drug users also avail of its multi-disciplinary services.

Application and registration are done personally by the clients, or through referrals made by the other agencies. To serve the clients fully, the multi-disciplinary after-care approach is used. The Malaya Centre aside from the services being rendered by its own staff and psychiatrist-consultant, has also made arrangement with the Dangerous Drugs Board to fill in what they lack. Laboratory examinations and psychiatric evaluations are done by the DDB upon referral Intake interviews, psychological testing and diagnostic evaluation, individual, group and family therapy, occupational therapy and other supportive activities are offered, but the following highlights the services -

1. After-care through periodic follow-up in schools and work, and home visitation to their respective communities.

2. Social placement and employment schemes-clients are recommended to available skills training and employment resources if after the assessment, they are found psychologically, socially and potentially fit, and their interest and willingness for such assistance is elicited and clarified prior to referrals. Likewise, schooling programme is pursued with the consent and coordination of the client's parents.

3. Community relation and referral -

In this connection, the "Baranganic" approach is used to elicit the cooperation of the community. They are planning to tap Barangay assemblies and with this, they are optimistic that sooner they can form the Board of Advisers. From this point, it is envisioned that close links with the top business holders in their locality, who can readily assist them in giving jobs to out-of school and unemployed clients can be developed.

3. **Treatment and Rehabilitation Division, Dangerous Drugs Board**

This division apart from being the policy making, program planning and coordinating arm of the Board relative to treatment and rehabilitation of drug dependents and also renders direct clinical services in the form of probation and follow-up of cases.

V. EFFICACY OF THE TREATMENT PROGRAMME

A study of the rehabilitation programme for drug dependents in the Philippines was conducted by the technical committee of the Board in 1975 to make a systematized assessment of the status of existing drug rehabilitation centres and look into the philosophy, operational procedures and efficacy of treatment and rehabilitation programmes.

953 discharges for the year 1973-74 were used as the subjects. A criteria were set by the committee and used in this study.

The criteria consisted of the following

(a) **Physical**

1. Is free from signs and symptoms referrable to the use of dangerous drugs.

(b) **Psychological/Behavioural**

1. Has developed self-awareness and learned to accept self;
2. Has developed honesty and self-confidence;
3. Has developed responsible concern for self and others;
4. Has found positive alternatives to basic drives;
5. Has established a goal and with strong desire to achieve the goal;
6. Obtain satisfaction from what he does.

(c) **Social**

1. Is able to relate self and react adequately with the family, classmates, co-workers and supervisors.

2. Acts according to the norms and standards of society.

(d) **Vocational**

1. Has developed good studying and working habits.

Out of 953 clients discharged from all the centres in 1973-74 only 141 were interviewed and included in the study. Of the 141 subjects interviewed, 41 were discharged as rehabilitated and 100 were discharged for reasons other than being rehabilitated.

Of the 41 who graduated from the programme only 12 or approximately 9% met the DDB criteria to be considered rehabilitated.

Because of the limited number of cases included in this study, the Board feels that there should be another study to be conducted which will cover discharged clients from all the centres for the past three years.

VI. PROBLEMS ENCOUNTERED

In our field inspection trips, supervision, and coordination of the different centres, we observed the following problems:

1. inadequate training of centre's staff.

2. fast turn over of staff because salary structure was felt as unreasonable

3. management of centre's needs is low.

VII. CONCLUSION

At present, there is no heroin problem in the Philippines. Drugs of abuse are mainly classified as soft drugs. Furthermore, the DDB, through the TRD, has effected a more closer and congenial relationship as well as better coordination and collaboration with agencies involved in treatment and rehabilitation through its inter-agency committee.

It is envisioned that problems that may exist in this area can easily be threshed out and remedial measures to problems can be effected immediately.

The different centres, have varied modalities of approach, and the Board does not mind this and is in fact encouraging new concepts, provided that the primordial goal of treatment and rehabilitation, i.e., to make the dependent live a normal productive life in society is ultimately achieved.

VIII. FUTURE PLANS

1. Training of centre's staff has been planned and to be undertaken within this year.

2. A plan to be implemented also within this year is the cross-posting of staff whose objectives are as follows:

   a. To foster closer and congenial relationship among the different centre's staff.

   b. To gather first-hand knowledge about the different centre's activities and programmes.

   c. To implement some of the knowledge gathered that will fit into their total programme of rehabilitation.

   The initial plan to cross post staff within the country and hopefully later this project will be implemented on international level.

3. Strengthening of the staff complement of the TRD to meet the growing needs in the field of treatment and rehabilitation.

4. There is a plan to expand treatment and rehabilitation services for drug dependents in the regional level through the encouragement of other agencies to establish Centres in areas where there is an increase in drug incidence.

5. Other plan is to expand the Central Screening and Referral Unit in the Regional level and commodity assistance to regional laboratories for them to be able to undertake examination of seized drugs and drugs in the body fluids.

6. Maintenance and expansion of out-going projects.

DISCUSSION

In discussing the paper of Dr Patrick Hughes on "Developing an international methodology for evaluation of treatment and rehabilitation approaches", the following comments were noted:[1]

1. While the suggested instrument for treatment evaluation appears to be adequate as a baseline, there is little experience in this field in some of the countries.

2. Some participants reported difficulty finding sufficient patients for systematic treatment evaluation studies. This is a common problem in conducting evaluation studies for treatment of any disorder. The

[1] Dr Hughes of WHO regretted not being present at the discussions due to the changed date of the Workshop, but has subsequently answered questions raised.

reason for this is that if an evaluation study compares two treatment groups of only 5 or 10 patients each, differences in their relative success rates must be dramatic if they are to have statistical significance. If there is no statistical significance, we have no degree of certainty that the differences would not have occurred by chance alone. In the treatment evaluation studies now underway to finalize the WHO instruments, at least 30 drug abusers are randomly assigned to any treatment approach being evaluated. It is expected that where one treatment approach gives clearly superior success rates, these differences will be found to be statistically significant. For programmes that treat very few drug users it may not be practical to conduct systematic treatment evaluation studies unless they combine their data with those of other programmes.

3. Concern was expressed that the instrument is being used in centres where the drug problems are caused primarily by opium and heroin use; and whether it can be used to evaluate treatment of psychotropic drug users. Dr Hughes clarified that the instrument is also being tested in a study of psychotropic drug users and core outcome variables such as drug use, employment, and legal status appear to be important treatment outcome indicators for most forms of drug dependence.

4. Additional issues were raised such as the need for data gathering staff to be adequately trained if the results are to be meaningful.

5. Participants who were not participating in the WHO study were interested in receiving copies of the forms. Dr Hughes indicated that the participants from countries not participating in the study will be sent copies. Others who wish to receive copies can obtain them by writing to the Division of Mental Health,WHO, Geneva. They will not be published, however, until they have been finalized after being tested in a number of countries during the coming year.

6. The question was raised as to criteria for judging a patient to be rehabilitated. Dr Hughes indicated that there are no such established and internationally recognised criteria, but the current collaborative testing of the WHO evaluation instruments will collect data on a variety of measures relevant to rehabilitation outcome. Several measures mentioned earlier, such as drug use, employment and legal status are considered core items because the subjects' responses can be validated by other sources of information. For example, the majority of studies now being conducted to finalize the instruments are collecting urine for laboratory testing at the time of follow-up as a validity check on the subjects self report of drug use. Information are also collected on living situation and family relationships, but such measures of social functioning may be too culture specific to establish universal criteria for success. Hopefully, we will be able to speak of this issue more knowledgeably in a year from now.

The paper presented by DR. V. SATKUNANAYAGAM on the "Treatment of Drug Dependence in Sri Lanka" was discussed with great interest by the participants.

From the discussions it was understood that opium is mostly eaten in the country, although some prefer to smoke it. The price of opium which comes mainly from India is about two rupees (12 US cents) per piece. Unlike other countries the average age of those receiving treatment is relatively high 30 - 85 years of age.

One of the problems is the absense of special treatment facilities for addicts including alcoholics. At present they can only be treated in general psychiatric wards.

There is also an extensive use of ganja in the country. Although illegal, the plant is very widely grown. Ganja use does not represent yet a major social or health problem in the country.

DR. J. B. HOLLINRAKE's paper on "Social Rehabilitation of Opiate Users in Hong Kong" raised many pertinent questions, summarised as follows:

1. "We do try to detect our failings, and we do try to correct them". The problem of drug addiction is inter-related with many factors in the Hong Kong situation, for instance over-crowding, limited housing facilities, education, welfare, corruption and so forth. The Government of Hong Kong is constantly trying to identify these problems and making every effort possible to correct them.

2. **Charges for treatment programmes**

   This question applies of course only to those drug dependents presenting themselves voluntarily for treatment. In the case of the SARDA programmes no charge is made. In the case of the Methadone programmes provided by the Medical and Health Department, a nominal charge is made to the patient of $ HK 1 (one) per visit.

3. **Special provisions for young persons**

   Young persons, ie. those in the late teens and early twenties, admitted to the SARDA programme have invariably terminated their formal education some considerable time prior to their presentation. In practice we have found that attempts to re-institute formal education in such cases are not fruitful, possibly because the dependent lacks the necessary mental discipline to benefit from such measures. On the other hand we are very much aware of the necessity of training in basic technical skills those who have no such skills and we tend to emphasize this aspect of technical training to assist the rehabilitated to secure employment following his return to the community.

4. **Compulsory treatment and rehabilitation**

   SARDA does not practise compulsory treatment and rehabilitation. The programme is entirely voluntary with an 'open door' policy. A very small proportion of the admissions (2%) however are probationers who have been referred to the SARDA programme by the Courts.

5. **Methadone Maintenance - Dosage**

   The standard maintenance dose which is used is in the region of 40 mgm per day. Individual medical officers may, however, deviate from this figure depending on individual circumstances.

6. **Methadone Maintenance/Detoxification Programmes - Numbers**

   At the present time the number of dependents currently registered in the out-patient methadone programme is in the region of 7640 with an average daily attendance of 5,300.

7. **Acupuncture and A. E. S. Treatment**

   A pilot study of this modality is presently in the final stages of investigation, under the direction of Dr. H. L. Wen. The report on this scheme will be available at the end of next month.

8. **Age regulation**

   The ordinance permits that a dependent under the age of 19 may remain in the Shek Kwu Chau treatment centre for 12 months. Those over that age may have six months residential rehabilitation in the Shek Kwu Chau Centre.

9. **Medical Findings(Complications) in Newly Admitted Dependents**

   Respiratory ailments such as emphysema and chronic bronchitis are frequent findings, possibly related to the tobacco habit. Ulcer syndrome is also a frequent finding as well as malnutrition. More rarely one finds hepatitis and one or other of the veneral diseases.

10. **Rate of Recidivism**

    Since there are several programmes in operation in Hong Kong the true rate of recidivism is difficult to assess at present. Later this year however the central Registry of drug dependents will be releasing its computerized data, which will help to identify this figure more accurately.

11. **Number of Personnel in Shek Kwu Chau**

    The centre accommodates 500 residents; there are approximately 60 residential staff and approximately one third of these are ex-drug dependents.

12. **SARDA success rate**

    The "success rate" based on two year follow-up from the date of admission to Shek Kwu Chau, and periodic urine tests, is 38.4% of those who completed the full course of rehabilitation, ie. five months.

13. **Number of persons completing the course in Shek Kwu Chau**

Approximately 50% of admissions stay on the Island for five months although this figure varies depending on factors such as the occurrence of Chinese New Year, work availability, family crisis etc. There are of course those who do not wish to continue their residential rehabilitation for many reasons.

14. **The average length of stay**

The average length of stay is clearly 2½ months - the early discharges leave within this period.

15. **The cost of the methadone maintenance/detoxification programme**

According to the number of dependents who are involved in this programme the present cost is approximately in the region of $ 2.50 per patient. (Hong Kong dollars.)

16. **Advantages and disadvantages of an Island Centre**

The two principal advantages are security and management/development. The principal disadvantages are:

(1) Initial capital outlay
(2) Transport of materials, staff, visitors
(3) Absence of facilities for staff families eg. schooling and so forth.

17. **Comparative effectiveness of Prison (compulsory) and SARDA (voluntary) after-care**

To my knowledge no special study has been made on this aspect and it would be unfair for me to make comparisons on a matter on which I have no precise knowledge.

18. **Screening of patients applying for admission to Shek Kwu Chau**

Formerly screening of triad leaders, violent criminals etc. was carried out in order to maintain stability within the centre. Experience however showed us that this was unnecessary and no screening measures are carried out now. All applicants are admitted irrespective of their background.

19. **Re-admission to Shek Kwu Chau**

Former residents who have relapsed to drugs will be re-admitted to Shek Kwu Chau on application. Re-admission date is scheduled not before 9 months from the original date of admission. This is to ensure that re-admissions do not return to the centre, whilst former patients are still present from the previous admission (in the case of

early discharges). For those who have completed six months of residential rehabilitation, they will have a minimum of three months in the community before re-admission.

Following the paper of DR. ERWIN WIDJONO on "Review of Drug Dependence treatment and rehabilitation in Indonesia," several questions and issues were raised during the discussion, such as

1. Cold turkey treatment
2. Separation of female from male clients.
3. Size of rehabilitation centre
4. Finding employment after release from rehabilitation
5. Difficulties during re-entry phase
6. Maximum length of stay

DR. R. M. SAN PEDRO's presentation of the "Overview of treatment services offered to drug users in the philippines" raised several pertinent questions:

1. Limited studies had been conducted on former heroin addicts in the country. Those who have come in contact with presently existing facilities, indicate, that a few of them abuse alcohol and some abuse Theranex (dextroprophoxyphene).

2. On the subject as to what criteria is used when decision is taken to refer a patient to an out-patient centre or to a rehabilitation centre it was stated that the Philippines use the classification of Dr. Helen Nowlis; those who are experimental, casual or occasional users are referred to the out-patient clinics, while those who are regular and heavy abusers, particularly those who are already taking drugs through the parental route are referred to the residential centres.

3. On the question concerning the size of centres the following should be said:
In the Philippines there are five major residential centres. DARE has five branches which can comfortably accommodate 400 - 500 patients. The NBI unit which is the only government centre can accommodate 100 patients and the DARN centre can accommodate 100 patients also. PREDA has 50-60 beds capacity while NFPI can only accommodate 30 patients.

4. Several questions were directed to the subject of what punishments are used for those breaking rules. Each centre has its own houserules. Generally, however, cancellation of home leave, visits of relatives, reduction in the number of cigarettes to be smoked, cleaning rest-rooms for several days, not being allowed to sit in a chair during meal time, isolation, donning of placards and head shaving.

5. Is occasional cannabis or alcohol use permitted in rehabilitation centres in this region?
No.

6. On the issue of after-care services it was stated that patients on after-care are either voluntary or court-referred. They are required to report to the out-patient clinic weekly or fortnightly. In the clinic they are subjected to individual counselling as well as to group therapy. There is also a monthly parent-patient dialogue, where they verbalize their conflicts and problems bridging the gap that exists among them. Patients are also given lectures on mental health and about the dangerous drugs law.

7. The composition of personnel in different rehabilitation centres are as follows :

- medical officers
- social worker
- psychologist
- nurses
- nurse aides
- vocational instructors
- security guards

8. The kind of training required for ex-addicts before they can be used as therapists is that they must be graduates of their programme and they have to undergo "attitudinal training".

9. How are jobs ensured for the vocationally trained addicts after discharge?
The interagency committee on Treatment and Rehabilitation of the Dangerous Drugs Board has entered into an agreement with the national manpower and youth development council for the agency to provide skills training to the patients. It is hoped that the training will provide the clients with apprenticeship opportunities and if they prove capable they may eventually be hired by the industrial establishment.

DEVELOPING A NATIONAL REHABILITATION PROGRAMME FOR DRUG DEPENDENTS IN MALAYSIA

By

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Introduction

This paper attempts to explain the background, the legal structure and the system of the rehabilitation programme in Malayisa. The need for such a programme emerged when as far back as 1974 there was evidence of an increase of drug abuse and addiction especially among the youth. The number of drug dependents is now estimated to be 52,000 based on the statistics of the Ministry of Welfare Services and there is reason to believe that this number continues to grow. The drug epidemic is partly aggravated by the rapid process of social change arising from urbanisation, particularly massive migration of young school leavers from rural to urban settings in search for a better living. It is realised that punitive measures are not the answer to the problem, since our experience has shown that the drug dependent is frequently **the product of a broken home.** He has an inadequate personality, manifested by a deep sense of insecurity and a low level of stress tolerance. He may, for example, in order to avoid a painful experience, rely on chemicals of one nature or another to seek escapism. Since it is not the drug but his weak personality that makes him a drug dependent, our approach is to conceive him as one who needs help and not punishment. His physical and psychological dependence on drugs is therefore a compensatory behaviour and forms part of his reaction in dealing with stress and strain, which becomes more acute from pressures of living.

The problem of drug addiction is multi-faceted and has to be understood beyond the immediate symptoms of personal and social distress presented by the addict. His difficulties do not arise in a social vaccum but are inter-woven with his net-work of relationships in social situations. With this as the concept and the background to the problem, it became imperative for the Government to formulate a policy for the rehabilitation of the drug dependents who, unless they are rehabilitated and reintegrated into the society, would pose a serious threat to the progress of the country. It is realised that for the treatment and rehabilitation programme to be effective, it must allow a certain degree of flexibility in approaches and modalities recognising the concept of human differences. To this extent, this policy is now reflected in the legal provisions which basically seek to encourage early case identification and intervention, medical treatment

cum psycho-social support, and social restoration through supervision or aftercare, directed to enable the dependent to become a drug-free individual.

2. Legal framework

Having accepted the principle and need for rehabilitation, the Government amended the Dangerous Drugs Ordinance 1952, which hitherto had not included rehabilitative measures, vide the Dangerous Drugs (Amendment) Act, 1975. (Please see Appendix A). This was the first time when legal provision was made for the rehabilitation of drug dependents, and the Ministry of Welfare Services was mandated to establish and administer a rehabilitation programme with the Ministry of Health providing detection and detoxification facilities in hospitals as a complementary component. In order to implement the provisions of this new Amendment Act with the minimum delay, the Ministry of Welfare Services introduced a crash programme by modifying three existing welfare institutions to provide residential rehabilitation for drug dependents. At the same time, the Ministry of Health gazetted 24 hospitals, 17 for detection and 7 for detoxification purposes. The utilisation of these hospitals represents a satisfactory temporary arrangement as it permits a wider geographical coverage for drug dependents who require medical detection and treatment as the first phase in rehabilitation.

In the light of experience, the Ministry of Welfare Services initiated further improvement in its rehabilitation policy and decided to build comprehensive rehabilitation centres under the Third Malaysia Plan. These new features have been reflected in the subsequent amendment to the Dangerous Drugs Ordinance. Therefore the Dangerous Drug (Amendment) Act 1977, which came into force on 15th November 1977, provides only for deteciton centres to be established by the Ministry of Health while the detoxification aspect of medical treatment becomes the responsibility of the Ministry of Welfare Services. (Please see Appendix B) However, during the interim period until the new centres of the Ministry of Welfare Services are operational, the hospitals will continue to detoxify drug dependents.

3. The drug dependent

Who can be admitted to the rehabilitation centres? The law is only concerned with the drug dependent for the purpose of rehabilitation. He is a person who uses a dangerous drug and as a result of which undergoes a psychic and sometimes physical state characterised by behavioural and other responses with compulsion to take the drug continuously or periodically in order to experience such psychic effect. This is derived from the W. H. O. concept and obviously requires two elements of proof (a) taking of a dangerous drug and (b) exhibiting psychological and or physical dependence on the drug.

4. Judicial orders

To understand the various intervention procedures involving social welfare officers and the courts, and the judicial orders that may be made in respect of drug dependents, it would be helpful to categorise such persons into three categories, viz.

(a) The suspected drug dependant;
(b) The drug dependant convicted of an offence under the Dangerous Drugs Ordinance;
(c) The volunteer drug dependant.

(a) The suspected drug dependant may be produced by a social welfare officer or a police officer before a Magistrate and be remanded in a detection centre. If he is certified to be a drug dependant, and is indicated to be suitable in the report of the social welfare officer, he may be admitted by the Court to a rehabilitation centre. The Court, however, has the option of placing him under the non-institutional supervision of a social welfare officer for a period of two years provided he enters into a bond to be of good behaviour. (Please see Appendix C)

(b) The drug dependant who has been convicted of a criminal offence under the Dangerous Drugs Ordinance may, if he is under 21 years of age, and subject to a favourable report by the social welfare officer, be admitted by the Court to a rehabilitation centre for a period of 6 months. It must be emphasised that the Court may, as an alternative, release such person on probation for a period of two years with or without conviction on condition that he enters into a bond to be of good behaviour. Again, it must be understood that the Court's power is not limited to either making a rehabilitation centre order or probation order. It may impose imprisonment of fine or both on the offender if it deems fit.

(c) An adult drug dependant may volunteer himself for admission to a rehabilitation centre by first making the application to a social welfare officer. In the case of a minor his parent or guardian shall apply on his behalf. Before the application can be considered, the social welfare officer shall require the applicant to be medically examined in a detection centre. If he is certified to be a drug dependent, the application will then be referred to a Magistrate, who after considering the report of the social welfare officer may either approve his admission to a rehabilitation centre or place him under the supervision of a social welfare officer. Any dependant, so subjected to a judicial order, will be required to comply with the relevant provisions of the law as though the order had been made on the court's own motion.

The Court, in all instances, when making a rehabilitation centre order, may also make a contribution order for the up keep of dependants, realising that self-responsibility is an important concept in their rehabilitation.

5. Joint ministerial participation

Reference has been made to the joint responsibility between the Ministry of Welfare Services and the Ministry of Health in the rehabilitation programme. Although it seems odd, nevertheless this arrangment has produced satisfactory results. It may well be that ideally detection and detoxification should be built-in-functions of a comprehensive rehabilitation centre. But present conditions in Malaysia make it most uneconomical if every suspected drug dependant is to be medically examined and observed for detection purposes at a rehabilitation centre. As indicated earlier, this joint participation arose from the need to maximise the utilisation of the existing available infra-structures in order to give effects to the legislative provisions introduced in 1975, which for the first time, provided rehabilitation measures for drug dependants. Thus the artificial division between the two integrated aspects of rehabilitation - detection and detoxification in hospitals and residential care in welfare rehabilitation centres. (Please see the Treatment and Rehabilitation Chart in Appendix D)

6. Detection and detoxification

These two integrated aspects may be described as the first phase in rehabilitation primarily designed to remove the effect of drugs from the patient and to prevent complications that may result from withdrawal of drugs. The law requires every category of dependant to be first medically examined and observed before any order can be made.

Under the present arrangement, there is an apparent need for the Ministry of Health to increase its facilities for detection and detoxification until such time when the latter function can be undertaken by the Ministry of Welfare Services. It is obvious that the 24 hospitals gazetted throughout Peninsular Malaysia, with only 7 major hospitals having detoxification facilities, are inadquate.

However, it is encouraging to note that the Ministry of Health has a long term plan to gazette every hospital in the country as a detection centre. This will considerably increase the present number of 74 beds. A proposal is also under study to increase the number of 7 detoxification centres to 14 thus increasing the 140 beds now available.

7. Rehabilitation centres

Residential rehabilitation forms part of the second phase of the rehabilitation programme for those admitted to rehabilitation centres in lieu of supervision in the open community. It will be recalled that the Court has the alternative choice of placing a drug dependant on probation. Institutional treatment embraces the concept that a drug dependant is not a criminal but a sick person, at least in the emotional sense of the word, and therefore requires treatment. He is in need of psycho-social support, through counselling, supervision, vocational and diversional therapy, even though drugs have been physically withdrawn from his body. A therapeutic programme of this nature evidently requires a controlled environment

with trained staff to administer it. The trained institutional staff focus on the psychosocial needs of the drug dependant; to help him understand better the adverse effects of drug dependence, to increase his motivation to live without drugs and to build up his emotional resistence to face the pressures of living on discharge from the centre.

The Ministry of Welfare Services has been operating three rehabilitation centres since October, 1975; two with maximum accommodation for 100 residents each and the third for 180. Thus a total of 380 drug dependants can now be rehabilitated at any one time as compared to 300 in 1975. They are not centres specially built for this purpose but improvised and renovated from institutions established for chronically ill persons in order to meet an emergency need arising from the implementation of the law.

Since October, 1975 to March 1978 a total of 1857 drug dependants have been admitted to these 3 centres and 1,492 have been discharged leaving 365 still undergoing rehabilitation. (Please see Appendix E for details of drug dependants in rehabilitation centres).

The need for increased accommodation has been felt and therefore under the Third Malaysia Plan (1976-1980) a new comprehensive centre will be established in Bosut, Trengganu to provide beds for 133 residents; the existing centre in Kuala Kubu Baru, Selangor will also be renovated into a comprehensive centre to increase the intake from the present 180 to 300 residents. By 1979 when these two projects are completed the total number of places will have been increased from 380 to 633. Action is being taken to increase the intake in Besut by another 160 and two new additional comprehensive centres, one in Kedah and the other in Johor will also be submitted for approval at the mid-term review of the Third Malaysia Plan in 1978. Each is designed for 300 beds. Thus by the end of 1980, there will be 6 centres providing accommodation for 1,393 beds.

Of all the factors involved in the rehabilitation process, motivation of the dependant himself has been the most important. Whether this stems from his desire to be rid of addiction, through pressure from the family or being afraid of the law is not of great importance as long as such motivation provides him with a foundation to try and reconstruct a new life.

In view of the vital importance of motivation, there is often the criticism of compulsion being directed towards a drug dependant to undergo treatment. One must, however, understand that drug addiction presents a serious personal problem with grave consequences on the community, like any serious problem of public health involving, for instance, smallpox or cholera. Therefore, intervention by the authorities is necessary at least on humanitarian grounds designed to isolate those infected from the rest of the community. In the field of rehaibilitation the compulsory approach is only applied in the best interest of the dependant whereby he is required to be admitted into a centre where he can decide whether or not to free himself from drug addiction. The least that could be afforded to him is the chance to motivate himself within the therapeutic environment.

The new Amendment Act of 1977 stipulates the period of rehabilitation as six months, subject to the proviso that this period may be increased by another six months if the Board of Visitors so deems necessary. Thus, in effect the rehabilitation centre order is an indeterminate period based on a realistic minimum and an acceptable maximum with the aim of keeping the exact period flexible. Further provision for this is reflected in the fact that the Board may release a resident after four months from the date of his admission. In exceptional cases, the Minister of Welfare Services may release any one at any time she deems desirable. The principle underlying such provision recognises the differential needs of dependants. With this in mind, it logically follows that flexibility within a stipulated period is desirable in relation to differences in individual responses to treatment needs, depending on the individual's attitude and the time required by the staff to succeed in motivating him.

Malaysia is relatively new in the field of drug rehabilitation, but as far as is practicable, its rehabilitation centres adhere generally to certain underlying principles:-

(a) The rehabilitation programme is directed in such a way that the resident realises beyond any doubt that he himself is responsible for deriving the maximum benefit from his stay at the centre. Motivation, as mentioned earlier, plays a crucial role in the rehabilitation process. The therapeutic programme is backed up by psychological treatment aided by individual and group counselling, work therapy, moral and religious instruction and a wide range of recreational activities.

(b) The centres are situated some distance away from the concentrated urbanised areas to make separation of the residents from his family possible. At the same time they are not too far from essential facilities of medical care, access of persons and groups offering voluntary services.

(c) The Centres attempt to offer a full and varied programme of purposeful activities designed to encourage the residents to return to a meaningful life with confidence and self-respect restored.

(d) They strive to be completely drug free without assuming a prison-like atmosphere. However, the character of the institution is not static, but flexible to allow variation to meet with changing circumstances.

(e) Their ultimate goal is to provide a comprehensive rehabilitative programme aimed at reconstructing and remoulding the drug dependent to become a responsible productive citizen.

To reinforce the underlying principles of the rehabilitation process, rules consistent with the spirit of the law relating to administration and management of the centres are applied. They cover a wide range of matters relating to the appointment of a Board of Visitors and its responsibilities;

the responsibilities of the key staff such as the Principal and the Medical Officer; the responsibilities, obligations and privileges of residents and other ancilliary measures pertaining to admission, discharge, discipline, punishment and review of progress of residents, etc. (Please see Appendix F - Rehabilitation Centre Rules).

Members of the Board of Visitors are appointed by the Minister of Welfare Services from civic-minded voluntary workers and are generally responsible for the welfare of residents in the centres. Approval for discharges and arrangements for aftercare are two main functions of the Board. Their involvement in the administration of the centre is to encourage public participation in the rehabilitation programme.

8. Aftercare

Aftercare may be considered as the third phase in the rehabilitation programme. It is complementary to residential care, and is regarded as a continuation of the rehabilitation process within the community after release from the centre. Progress made by any resident in a centre is not necessarily an indication of success. The crucial test comes when the discharged resident seeks reintegration into the community and the most difficult period is the transitional phase from a controlled environment to an open life when he will need all possible assistance. This concept is reflected in the law and therefore a two year period of aftercare is mandatory.

A sound comprehensive aftercare service evidently requires community participation. It is encouraging to note that Pemadam (National Association Against Drug Abuse, Malaysia), a pioneer voluntary body, has initiated plans set up half-way houses and day centres in the big towns. The former will cater for drug dependents who are discharged from rehabilitation centres while the latter take care of probationers. These centres will provide basic facilities which include individual and group counselling, assistance on job placement, medical tests and other psycho-social support designed to promote integration of the individual into the society.

In a true treatment setting, aftercare begins with commencement of treatment in the centre. A good deal has to be done to prepare the resident for the day when he will once again return probably to the same environment from which he came. Therefore the establishment of a solid foundation of trust and friendship between the resident and the aftercare officer must be built prior to release. Employment prospects must be investigated and a job found prior to discharge. The social worker has to understand the underlying personality and psychological conflicts that may have contributed to his client's addiction, and above all to accept and counsel him to live without dependence on drugs.

Since October 1975, a total of 5,167 drug dependents have been referred to the Department of Social Welfare and at the end of March this year 1,842 persons are under supervision of whom 855 are on the Aftercare Register. The number is expected to rise steadily now that aftercare has

the force of law with the implementation of the new legislation from 15th November, 1977. (Please see Appendix G - Statistics on Drug Dependents referral and supervision)

Recall from aftercare in certain instances is desirable and in the interest of the supervisee. Failure to respond to a recall order to return to the centre renders the supervisee liable to be arrested by a police officer. On return to the centre he may be further detained for a period not exceeding six months. This is to ensure that he is not allowed to relapse without being given a further chance of being helped.

9. Community Support

No administration and management of any drug rehabilitation centre can be completed without the support of the community. In the Malaysian experience, apart from the Centre's Board of Visitors, provision is also made for the appointment of Rehabilitation Committees which should serve as a channel for expression of public concern and interest in voluntary welfare work relating to supervision and rehabilitation of drug dependents. The members of these committees, which may comprise teachers, employment exchange officials, religious, business or community leaders, will be appointed on district basis in the country and will perform their functions under the guidance of professional social workers. (Please see Appendix H - Rehabilitation Committee (Constitution and Duties) Regulation, 1977).

The contribution of private rehabilitation centres is also appreciated but in order to ensure that they function with minimum standards, they will be required to seek prior sanction of the Minister of Welfare Services to operate under the new Amendment Act. In order to comply with the requirements of the law, rules for the administration and management of the already established Help Centre in Perak have been formulated by the Ministry of Welfare Services. This private Centre will continue to operate on therapeutic community principles subject to the Ministry of Welfare Services exercising its right in regulating and monitoring the centre's system of admission, discharge and applying aftercare to its discharge residents. The rationale is to synthesise the integrated programme to achieve maximum effectiveness.

In order to formulate reliable statistical data relating to the incidence of drug dependents the new law requires all registered medical practitioners to notify the Minister of Health of persons treated by them. This system will supplement the Central Data Bank operated by the University Sains, Malaysia, which is fed by the Government agencies concerned: the Ministry of Welfare Services, the Ministry of Health, the Police and the Central Narcotics Bureau.

10. Conclusion

The Government of Malaysia, through the two principal agencies, the Ministry of Welfare Services and the Ministry of Health is deeply concerned and determined to succeed in rehabilitating drug dependents

in the country. The drug rehabilitation programme is a relatively new scene in Malaysia and is being constantly reviewed and developed.

To this extent, policies and legislation are continuously reviewed so as not to leave any stone unturned in search for the most effective method to combat the problem. Technical expertise and assistance from friendly countries is always welcome as the country develops and consolidates its programme. The Ministry of Welfare Services, as a future development, also plans to establish day centres and half-way houses in all the big towns throughout the country as vital components in the aftercare system. For in the last analysis, drug rehabilitation is, and must remain, a cardinal process to help the affected individual to live a life without drug.

Act A 293

DANGEROUS DRUGS (AMENDMENT) ACT, 1975

An Act to amend the Dangerous Drugs Ordinance, 1952.

BE IT ENACTED by the Duli Yang Maha Mulia Seri Paduka Baginda Yang di-Pertuan Agong with the advice and consent of the Dewan Negara and Dewan Rakyat in Parliament assembled, and by the authority of the same, as follows:

Short title. 1. This Act may be cited as the Dangerous Drugs (Amendment) Act, 1975.

Amendment of section 2. 30/52. 2. Section 2 of the Dangerous Drugs Ordinance, 1952 (hereinafter referred to as the Ordinance), is hereby amended -

(a) by adding immediately after the definition of "aircraft" appearing therein the following definitions -

" 'approved institution' means any institution approved by the Minister for Welfare Services for the treatment and rehabilitation of drug dependants;

'Bureau' means the Central Narcotics Bureau;";

(b) by adding immediately after the definition of "dangerous drug" appearing therein the following definition -

" 'drug dependant' means a person who through the use of any dangerous drug undergoes a psychic and sometimes physical state which is characterised by behavioural and other responses including the compulsion to take the drug on a continuous or periodic basis in order to experience its psychic effect and to avoid the discomfort of its absence;";

(c) by adding immediately after the definition of "opium poppy" appearing therein the following definition -

" 'police officer' includes the Director of the Bureau and any officer of the Bureau authorised by him;"; and

(d) by adding immediately after the definition of "syringe" appearing therein the following definition—

" 'trafficking', in relation to a dangerous drug, includes manufacturing, selling, giving, administering, transporting, sending, delivering, procuring, supplying or distributing otherwise than under the authority of this Ordinance or any other written law;".

New section 6 A. 3. The Ordinance is hereby amended by adding immediately after section 6 thereof the following new section 6A -

"Increased penalties in cases of raw opium

6A. Where an offence has been committed under section 4, 5 or 6 of this Ordinance and the subject matter is raw opium of more than 2 kilogrammes in weight, the offender shall also be punished with whipping of not less than three strokes."

Amendment of section 9. 4. Section 9 of the Ordinance is hereby amended by adding immediately after the word "imprisonment" appearing at the end of subsection (2) thereof the words "and where the subject matter is prepared opium of more than 250 grammes in weight, he shall also be punished with whipping of not less than three strokes."

New sections 37A and 37B. 5. The Ordinance is hereby amended by adding immediately after section 37 thereof the following new sections 37 A and 37B -

"Admission of statements in evidence.

37A. (1) Where any person is charged with any offence against this Ordinance any statement, whether such statement amounts to a confession or not or is oral or in writing, made at any time, whether before or after such person is charged and whether in the course of a police investigation or not and whether or not wholly or partly in anwswer to questions, by such person to or in the hearing of any police officer of or above the rank of Inspector or any senior officer of customs and whether or not interpreted to him by any other police officer or senior officer of customs or any other person concerned or not in the arrest, shall notwithstanding anything to the contrary contained in any written law, be admissible at his trial in evidence and if such person tenders himself as a witness, any such statement may be used in cross-examination and for the purpose of impeaching his credit:

Provided that no such statement shall be admissible or used as foresaid -

(a) if the making of the statement appears to the Court to have been caused by any inducement, threat or promise having reference to the charge against such person, proceeding from a person in authority and sufficient in the opinion of the Court to give such person grounds which would appear to him reasonable for supposing that by making it he would gain any advantage or avoid any evil of a temporal nature in reference to the proceeding against him; or

(b) in the case of a statement made by such person after his arrest, unless the Court is satisfied that a caution was administered to him in the following words or words to the like effect -

"It is my duty to warn you that you are not obliged to say anything or to answer any question, but anything you say, whether in answer to a question or not, may be given in evidence":

Provided that a statement made by any person before there is time to caution him shall not be rendered inadmissible in evidence merely by reason of no such caution having been given if it has been given as soon as possible.

(2) Notwithstanding anything to the contrary contained in any written law a person accused of an offence to which subsection (1) applies shall not be bound to answer any questions relating to such case after any such caution as aforesaid has been administered to him.

Treatment of drug dependants.

37B. (1) Any Social Welfare officer appointed by the Minister for Welfare Services for this purpose or any police officer not below the rank of Inspector may require any person whom he reasonably suspects to be a drug dependant to be medically examined or observed by a Government medical officer.

(2) If, as a result of such examination or observation, it appears to the Government medical officer that it is necessary for such person to undergo treatment at an approved institution, the Social Welfare officer or police officer, as the case may be, shall require such person to attend an approved institution for treatment for such period as he, after consulting the institution, may determine.

(3) Any person who refuses to undergo treatment at an approved institution as required under subsection (2) shall be guilty of an offence against this Ordinance.

(4) Where a person has been convicted of any offence against this Ordinance and the Court is satisfied from the report of the Social Welfare officer appointed under subsection (1) that such person is a drug dependant, it may, instead of sentencing him at once to any punishment, direct that he be required to undergo treatment at an approved institution for such period as the Court may specify, subject to his entering into a bond, with or without sureties as the Court may direct, to undergo such treatment for the said period and to appear and receive judgement if and when called upon during such period and in the meantime to keep the peace and be of good behaviour.

(5) A person who is a drug dependant may volunteer to undergo treatment at an approved institution and any statement made by such person for the purpose of undergoing such treatment shall not be inadmissible in evidence against him in respect of any subsequent prosecution for an offence under this Ordinance.

(6) In the case of a minor, the parent or guardian may send him for treatment at an approved institution, regardless of whether or not the minor is willing to undergo such treatment.

(7) An approved institution may admit any drug dependant for voluntary treatment on such terms and conditions as may be prescribed."

Amendment of section 39A

6. Section 39A of the Ordinance is hereby amended -

(a) by deleting the words "section 12 (2), 19 (4), 20 (5) or 22 (5) of" appearing therein; and

(b) by adding immediately after the word "years" appearing at the end thereof the words "and he shall also be punished with whipping of not less than six strokes".

New section 39B

7. The Ordinance is hereby amended by adding immediately after section 39A thereof the following new section 39B -

"Trafficking in dangerous drug.

39B. (1) No person shall, on his own behalf or on behalf of any other person, whether or not such other person is in West Malaysia -

(a) traffic in a dangerous drug;

(b) offer to traffic in a dangerous drug or;

(c) do or offer to do an act preparatory to or for the purpose of trafficking in a dangerous drug.

(2) Any person who contravenes any of the provisions of subsection (1) shall be guilty of an offence against this Ordinance and shall be punished on conviction with death or imprisonment for life and shall, if he is not sentenced to death, also be liable to whipping.

(3) Notwithstanding the provisions of section 41 or of any law to the contrary, every trial under subsection (2) shall be conducted in accordance with the provisions of Chapter XXII of the Criminal Procedure Code of the Federated Malay States or Chapter XXI of the Criminal Procedure Code of the Straits Settlements, as the case may be.

F. M. S. Cap. 6
S. S. Cap. 21

(4) A prosecution under this section shall not be instituted except by or with the consent of the Public Prosecutor:

Provided that a person may be arrested, or a warrant for his arrest may be issued and executed, and any such person may be remanded in custody notwithstanding that the consent of the Public Prosecutor to the institution of a prosecution for the offence has not been obtained, but the case shall not been further prosecuted until the consent has been cobtained.

LAWS OF MALAYSIA

Act A 389

DANGEROUS DRUGS (AMENDMENT) ACT 1977

An Act to amend the Dangerous Drugs Ordinance 1952

BE IT ENACTED by the Duli Yang Maha Mulia Seri Paduka Baginda Yang di-Pertuan Agong with the advice and consent of the Dewan Negara and Dewan Rakyat in Parliament assembled, and by the authority of the same, as follows:

Short title and commencement

1. This Act may be cited as the Dangerous Drugs (Amendment) Act 1977 and shall come into force on such date as the Minister of Welfare Services may by notification in the Gazette appoint.

Amendment long title. 30/52.

2. The long title to the Dangerous Drugs Ordinance 1952, which in this Act is referred to as the Ordinance, is amended by adding immediately after the word "substances" appearing therein the words "for matters relating to the treatment and rehabilitation of drug dependants".

Amendment of section 2.

3. Section 2 of the Ordinance is amended -

(a) by substituting for the definition of "approved institution" appearing therein the following new definition of "Board of Visitors" -

" "Board of Visitors" means the Board of Visitors appointed by the Minister of Welfare Services under section 25F;";

(b) by adding immediately after the definition of "dangerous drug" appearing therein the following new definitions of "detection centre" and "Director General" -

" "detection centre" means any place approved by the Minister where facilities are available for determining whether or not a person is a drug dependant;

a "Director General" means the Director General of Social Welfare;"; and

(c) by adding immediately after the definition of "registered pharmacist" appearing therein the following new definitions of "rehabilitation centre" and "rehabilitation committee" -

" "rehabilitation centre" means any institution approved by the Minister of Welfare Services for the treatment and rehabilitation of drug dependants;

"rehabilitation committee" means the committee appointed by the Minister of Welfare Services under section 25L;".

New Part VA.

4. The Ordinance is amended by adding immediately after Part V thereof the following new Part VA -

TREATMENT AND REHABILITATION OF DRUG DEPENDANTS

Medical examination, etc. of suspected drug dependant

25A. (1) Any Social Welfare officer appointed by the Minister of Welfare Services for this purpose or any police officer not below the rank of Inspector may require any person whom he reasonably suspects to be a drug dependant to be medically examined or observed by a medical officer at a detection centre.

(2) If, as a result of such examination or observation, it appears to the medical officer, in conjunction with the Social Welfare officer -

(a) that because the person has been certified to be a drug dependant by the medical officer it is necessary for such person to undergo treatment and rehabilitation at a rehabilitation centre then the Social Welfare officer shall require such person to attend a rehabilitation centre for a period of six months;

(b) that although that person has been certified to be a drug dependant by the medical officer it is not necessary for such person to undergo treatment and rehabilitation at a rehabilitation centre then the Social Welfare officer shall require such person to be supervised by a Social Welfare officer for a period of two years; or

(c) that because that person has been certified not to be a drug dependant by the medical officer it is not necessary for such person to undergo treatment and rehabilitation at a rehabilitation centre nor the supervision by a Social Welfare officer then the Social Welfare officer shall order his discharge.

(3) Any person who -

(a) refuses to undergo the medical examination or observation at a detection centre under subsection (1);

(b) refuses to undergo the treatment and rehabilitation at a rehabilitation centre or the supervision by a Social Welfare officer under subsection (2); or

(c) escapes from the lawful custody of a detection centre,

shall be guilty of an offence against this Ordinance.

Powers of Court in respect of drug dependants below the age of twenty-one

25B. (1) Where any person below the age of twenty-one years is found guilty of an offence against this Ordinance the Court shall consider a report of a Social Welfare officer and if the Court is satisfied that such a person is a drug dependant as certified by a medical officer and that having regard to the circumstances of the case and charactor, antecedents, health or mental condition of the person charged it is inexpedient to inflict the punishment provided, the Court may, with or without recording a conviction -

(a) release the offender on probation subject to his entering into a bond, with or without sureties, to be supervised by a Social Welfare officer for a period of two years and to be of good behaviour and to appear and receive judgement if and when called upon at any time during such period; or

(d) direct that the offender be required to undergo treatment and rehabilitation at a rehabilitation centre for a period of six months.

(2) A probation order made under paragraph (a) of subsection (1) shall contain such requirements as to residence, submission to periodical clinical and laboratory tests and any other requirements as the Court may consider necessary for securing the good conduct and supervision of the probationer or for preventing a repetition by him of the same offence or the commission of other offences.

Breach of bond.

25C. Any probationer who commits a breach of his bond shall be guilty of an offence against this Ordinance, and any Court which is satisfied by information on oath that the probationer has failed to observe any of the conditions of his bond, may issue a warrant for his apprehension, and deal with him for the offence in respect of which the probation order was made in any manner in which the Court could deal with him if it had just found him guilty of that offence.

Period of detention.

25D. The period of detention in a rehabilitation centre shall be for a period of six months:

Provided that -

(a) the Board of Visitors of a rehabilitation centre may, in its absolute discretion, shorten the period of detention for reasons which appear to it to be sufficient, if such person has already completed a period of four months in a rehabilitation centre; and

(d) no such person shall be released from a rehabilitation centre during the first four months of the period of detention without the consent of the Minister of Welfare Services in writing.

Further detention in a rehabilitation centre beyond period of order.

25E. If the person for the time being in charge of a rehabilitation centre is satisfied that a resident, whose period of detention therein is about to expire, needs further treatment and rehabilitation he may, if the Board of Visitors of the rehabilitation centre consent, detain him for a further period not exceeding six months.

Board of Visitors.

25F. The Minister of Welfare Services may appoint a Board of Visitors for each rehabilitation centre -

(a) to perform such duties and functions as the Minister of Welfare Services may by rules prescribe; and

(b) to advice and make recommendations to the Director General on such matters as the Director General may refer to it.

Admission of volunteers to a rehabilitation centre.

25G. (1) Any person may, and a parent or guardian shall, on behalf of a minor of which he is the parent or guardian, apply to a Social Welfare officer that he or such minor, as the case may be, be admitted to a rehabilitation centre.

(2) The Social Welfare officer shall require the applicant or the minor, as the case may be, to be medically examined or observed by a medical officer at a detection centre and the provision of section 25A of this Ordinance shall apply mutatis mutandis in the case of a volunteer drug dependant.

(3) A rehabilitation centre may admit any drug dependant for voluntary treatment and rehabilitation on such terms and conditions as may be prescribed.

(4) In the case of a minor the parent or guardian shall send him for treatment and rehabilitation at a rehabilitation centre, regardless of whether or not the minor is willing to undergo such treatment and rehabilitation.

Contribution order.

25H. (1) Where a Social Welfare officer admits any person as a volunteer or requires any person to be admitted to a rehabilitation centre, the Social Welfare officer may make a contribution order on the person requiring him to make such contributions in respect of his maintenance as the Social Welfare officer may deem fit.

(2) Where an order is made by a Court requiring any person to be admitted to a rehabilitation centre, the Court may make a contribution order on the person requiring him to make such contributions in respect of his maintenance as the Court may deem fit.

(3) Where a contribution order is made in respect of a minor, it shall be the duty of the parent or guardian of the said minor to comply with the contribution order.

(4) If any person shall wilfully neglect to comply with a contribution order, a Magistrate may for every breach of such order by warrant direct the amount due to be levied in the manner as provided by law for levying fines imposed by Magistrates, or may sentence such person to imprisonment for a term not exceeding one month for each month's contribution remaining unpaid.

Escape from lawful custody of a rehabilitation centre

25I. Any person who -

(a) while undergoing treatment and rehabilitation in a rehabilitation centre escapes from the lawful custody thereof; or

(b) being absent from the rehabilitation centre on leave of absence fails to return to the rehabilitation centre upon the expiration of his leave without reasonable cause.

shall be guilty of an offence against this Ordinance.

Transfer of a resident from one rehabilitation centre to another.

25J. If it appears to the Director General to be expedient in the interest of a resident that he should be transferred from one rehabilitation centre to another, it shall be lawful for the Director General to issue an order that such person shall be so transferred.

Aftercare of residents released from a rehabilitation centre.

25K. (1) A drug dependant admitted to a rehabilitation centre shall, after his release from the rehabilitation centre, be under the aftercare of a Social Welfare officer or of such other person as the rehabilitation committee shall appoint on the advice of the Social Welfare officer for a period of two years.

(2) Any person who is subject to aftercare on release from a rehabilitation centre shall, while under such supervision, comply with such conditions as may be specified in the aftercare order by the Board of Visitors of the rehabilitation centre.

(3) The Board of Visitors of a rehabilitation centre may, if it is satisfied that a person against whom an aftercare order is in force has failed to comply with any requirement of the order, make a recall against such person requiring him to return to the rehabilitation centre; and if he fails to do so, such person may be arrested by a police officer and be returned to the rehabilitation centre and be detained further for a period not exceeding six months as may be ordered by the Board of Visitors.

(4) The Board of Visitors of a rehabilitation centre may release a person who has been recalled from aftercare and exempt him from subsequent aftercare.

Rehabilitation committees.

25L. The Minister of Welfare Services may appoint rehabilitation committees for any State or district, as the case may be, and such committees shall be engaged in the welfare of drug dependants and shall assist the Social Welfare officers in the supervision and aftercare of such persons, and shall carry out any duties and functions as the Minister of Welfare Services may by rules prescribe.

Private rehabilitation centres.

25M. (1) The Minister of Welfare Services may, on the application of any person, approve the establishment of any private rehabilitation centre for the treatment and rehabilitation of drug dependants, upon such conditions as he may prescribe, and he may revoke any such approval at any time he may deem necessary.

(2) Notification of every such approval and of any revocation thereof shall be published in the Gazette.

(3) Any person who carries on the management of a private rehabilitation centre without the approval of the Minister of Welfare Services shall be guilty of an offence against this Ordinance and shall be liable on conviction to a fine not exceeding ten thousand ringgit or to imprisonment for a term not exceeding five years or to both such fine and imprisonment.

Compulsory notification of drug dependants.

25N. (1) It shall be the duty of a registered medical practitioner to notify the Minister, of persons who are being treated or rehabilitated by him as drug dependants. in accordance with rules as may be prescribed by the Minister.

(2) Any person who contravenes the provisions of this section shall be guilty of an offence against this Ordinance.

Rules.

250. The Minister of Welfare Services may make rules generally for carrying out the provisions of this Part, and without prejudice to the generality of such powers, may make rules providing for -

(a) the forms to be used for the purposes of this Part;

(b) the administration of a rehabilitation centre including care and treatment, detention, discipline, discharge and aftercare, temporary absence, maintenance, education and employment of persons admitted to a rehabilitation centre;

(c) the composition, duties, functions and procedure of conducting the business of the Board of Visitors and the rehabilitation committees;

(d) the establishment, management and control of private rehabilitation centres; and

(c) matters required to be prescribed under this Part.".

Repeal of section 37B.

5. Section 37B of the Ordinance is repealed.

LAWS OF MALAYSIA

Act A 413

DANGEROUS DRUGS (AMENDMENT) (No. 3) ACT 1977

An Act to amend the Dangerous Drugs Ordinance 1952.

[ ]

BE IT ENACTED by the Duli Yang Maha Mulia Seri Paduka Baginda Yang di-Pertuan Agong with the advice and consent of the Dewan Negara and Dewan Rakyat in Parliament assembled, and by the authority of the same, as follows:

1. This Act may be cited as the Dangerous Drugs (Amendment) (No. 3) Act 1977 and shall come into force on such date as the Minister of Welfare Services may by notification in the Gazette appoint. Short title and commencement.

2. Section 25A of the Dangerous Drugs Ordinance 1952, which in this Act is referred to as the Ordinance, is amended - Amendment of section 25A. 30/52.

(a) by substituting for subsections (1) and (2) the following -

"(1) Any Social Welfare officer or any police officer not below the rank of Sergeant or an officer-in-charge of a police station may take into his custody any person whom he reasonably suspects to be a drug dependant and shall within twenty-four hours produce such person before a Magistrate. If the Magistrate has reasonable cause to believe that the person so brought before him is a drug dependant, he may order such person to be remanded and be medically examined or observed by a medical officer at a detection centre.

(2) If, as a result of such medical examination or observation, such person is certified to be a drug dependant and accompanied by a report of a Social Welfare officer, the Magistrate in Chambers may -

(a) if it appears necessary for such person to undergo treatment and rehabilitation at a rehabilitation centre, order such person to attend a rehabilitation centre, for a period of six months; or

(b) if it appears not necessary for such person to undergo treatment and rehabilitation at a rehabilitation centre, order such person to be supervised by a Social Welfare officer for a period of two years, subject to such person entering into a bond, with or without sureties, and to appear and receive judgement if and when called upon at any time during such period:

Provided that in the case of a person below the age of 21 years, wherever practicable, the parent or guardian of such person shall be the surety for this purpose.";

(b) by adding the following new subsections (4), (5), (6), (7) and (8) -

"(4) It shall be the duty of the person in charge of a detection centre to immediately inform the Social Welfare officer of any person remanded for medical examination or observation at a detection centre to enable the Social Welfare officer to prepare the report as required for the purpose of subsection (2).

(5) It shall be the duty of the Social Welfare officer or the police officer whoever initiates action under subsection (1) to produce such person before a Magistrate in Chambers after such person has been medically examined or observed by a medical officer at a detection centre.

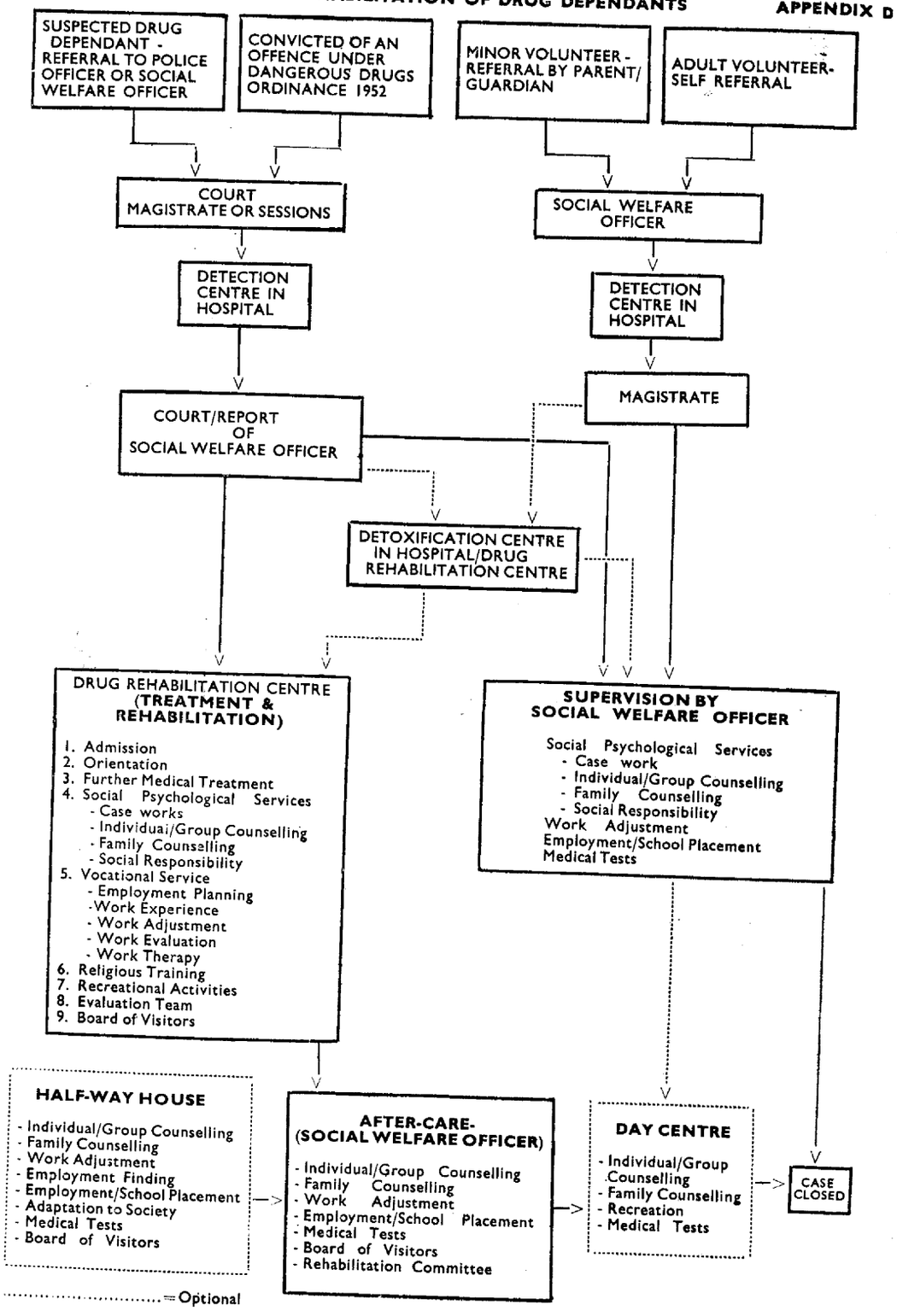
(6) A supervision order made under paragraph (b) of subsection (2) shall contain such requirements as to residence, submission to periodical clinical and laboratory tests and any other requirements as the Court may consider necessary for securing the good conduct and supervision of the supervisee or for preventing a repetition by him of the same offence or the commission of other offences.

(7) Any supervisee who commits a breach of his bond shall be guilty of an offence against this Ordinance, and any Court which is satisfied by information on oath that the supervisee has failed to observe any of the conditions of his bond, may issue a warrant for his apprehension, and deal with him for the offence in respect of which the supervision order was made in any manner in which the Court could deal with him if it had just found him guilty of that offence.

(8) An order made under subsection (1) or (2) shall be sufficient authority for the person in charge of a detection centre or a rehabilitation centre to detain any person in respect of whom an order has been made.".

TREATMENT AND REHABILITATION OF DRUG DEPENDANTS

APPENDIX D



APPENDIX E

MINISTRY OF WELFARE SERVICES MALAYSIA

Statistics of Drug Dependants in the Three Drug Rehabilitation Centres run by the Ministry of Welfare Services from 1.10.1975 to 31.3.1978

1. Admission

Institutions

a)	Bukit Mertajam Rehabilitation Centre ...	...	422
b)	Kuala Kubu Bharu Rehabilitation Centre ...	...	706
c)	Johor Bahru Rehabilitation Centre ...	...	729
		Total	1,857

2. Category of Admission

a)	Voluntary ...	...	948
b)	By SWO/Police/Narcotic Bureau ...	...	530
c)	With Court Order ...	...	377
d)	Transfer from other institutions ...	...	2
		Total	1,857

3. Discharges

Institutions

a)	Bukit Mertajam Rehabilitation Centre ...	...	328
b)	Kuala Kubu Bharu Rehabilitation Centre ...	...	535
c)	Johor Bahru Rehabilitation Centre ...	...	629
		Total	1,492

4. Category of Discharges

a)	Completion of Rehabilitation Period ...	...	939
b)	Before Completion of Rehabilitation Period ...	...	437
c)	Cancellation of name on abscondence ...	...	114
d)	Transfer to other institutions ...	...	2
		Total	1,492

5. Number in Register of Institutions as at 31.3.1978

Institutions

a) Bukit Mertajam Rehabilitation Centre		94
b) Kuala Kubu Bharu Rehabilitation Centre		171
c) Johor Bahru Rehabilitation Centre		100
	Total	365

6. Abscondence

a) Number of Abscondence to date	229
b) Number rearrested/returned	98
c) Name cancelled	114
d) Number not rearrested	17

7. Number in the institutions as at 31.3.1978 by Age Group

Age Group	
Under 12 years	—
12+to 15 years	—
15+to 18 years	21
18+to 21 years	104
21+to 30 years	213
30+to 40 years	24
40+and above	3
Total	365

8. Drug Abused on admission to Drug Rehabilitation Centres

Drug	
Cannabies	16
Opium	21
Morphine	139
Heroin	1,591
Amphetamine	1
M. X. Pills	4
Barbiturates	—
Poly Drugs	86
Other Drugs	—
Total	1,857

Dangerous Drugs Ordinance, 1952

Rehabilitation Centre Rules, 1977*

Ordinance — In exercise of the powers conferred by Section 25 (0) of Part VA of the Dangerous Drugs Ordinance, 1952, the Minister hereby makes the following rules:-

Citation — 1. (1) These Rules may be cited as the Rehabilitation Centre Rules, 1977, and shall apply to the Centres as listed in Schedule I.

(2) These Rules shall have effect from.....

Part I.

Interpretation — 2. In these Rules, unless the context otherwise requires:-

"Minister" means the Minister charged with the responsibility for Welfare Services;

"Director-General" means the Director-General of Social Welfare;

"Director" unless otherwise stated means the head of the Social Welfare Department of the State in which the Centre is situated;

"Principal" in relation to a Rehabilitation Centre means a person appointed to be a Principal of that Centre;

"Medical Officer" in relation to a Rehabilitation Centre means a person appointed to be a Medical Officer of that Centre;

"The Board" in relation to a Rehabilitation Centre means the Board of Visitors for the time being appointed under Rule 3 of these Rules;

"Centre" means a Rehabilitation Centre referred to in Rule I of these Rules;

"Resident" means any person, male or female who has been admitted to a Centre.

* Subject to amendment.

Part II

Board of Visitors

Appointment of Board of Visitors — 3.(1) The Minister may appoint a Board of Visitors consisting of not less than seven members for each Centre, at least two of whom shall be women and at least two shall be men. The Minister may also appoint representatives from Government Departments as ex-officio members if deemed necessary.

(2) The appointment shall be for a term not exceeding three years, but any member may be reappointed at the discretion of the Minister.

(3) The Principal, or in his absence, his Deputy, shall be an ex-officio member of the Board. No other member of the staff of the Social Welfare Department shall be eligible for appointment as a member of the Board.

Removal and resignation — 4. (1) The Minister may at any time if he thinks it expedient to do so revoke the appointment of any member of the Board without assigning any reason therefor, and any member may at any time resign from a Board.

(2) The Minister may appoint another member in place of any member whose appointment is revoked or who has resigned and may at any time appoint any person to be an additional member of a Board.

Chairman

5. The Minister shall appoint one of the members of the Board to be the Chairman.

Secretary and Treasurer

6. (1) The Board shall elect a Secretary and Treasurer or a Secretary and a Treasurer from among its members.

(2) The Secretary shall inform the Minister of any vacancy arising in the Board by reason of death or resignation of a member or from any other cause.

Meetings.

7. (1) The Board shall meet as far as practicable once a month. Every meeting shall be held at the Centre for which the Board is appointed. The Chairman or, in his absence, a member of the Board appointed by the members present, shall preside at the meetings.

(2) The Secretary shall give notice of every meeting to members of the Board and the Director.

(3) The Board may at its discretion, invite any member of the staff to be present at any of its meetings.

(4) One third of the members of the Board shall form a quorum.

(5) All questions arising at any meeting shall be decided by a majority of votes and each member present shall be entitled to one vote and in the case of equality of votes the Chairman or the member presiding shall have a casting vote.

Committees

8. The Board may appoint a Finance Committee and other committees with specific terms of reference as it may deem necessary for the efficient performance of its duties.

Auditors

9. The Board shall appoint auditors to audit its financial year accounts.

Part III

Responsibilities of the Board

Minutes

10. The Board and its committees shall keep minutes of the proceedings of meetings and copies thereof shall be forwarded to the Director-General, Director and to all members of the Board as soon as practicable after the meeting to which they relate.

Amenities Fund

11. The Board may establish an Amenities Fund:-

(a) into which shall be paid all monies received by way of gifts, donations, grants or requests made to the Centre by the public;

(b) into which shall be paid all other monies which may in any manner become payable to the Centre in respect of any fund raising projects carried out by the Board or any interests earned from deposits placed in any bank or from any other source;

(c) from which shall be defrayed the costs or part of the cost of providing additional amenities and programmes for the Centre.

Accounts

12. (1) The Treasurer shall keep proper accounts and records of all the income and expenditure in respect of the operation of all funds at its disposal and such accounts shall be open to inspection by the Director-General or his representatives.

(2) The Treasurer shall lay before the Board a statement of accounts in respect of the Amenities Fund and any other Fund at each of its monthly meetings.

Accounts to be audited

13. The Treasurer shall have the accounts of the Board audited at the close of the financial year and shall lay before the Board the statement of accounts together with a copy of any observation or statement by the Auditors appointed under Rule 9. Copies of the statement of accounts and the observation or statement of the Auditors shall be forwarded to the Director-General.

Visits by Board

14. The Board shall arrange by roster or otherwise frequent visits by members to the Centre which shall at all times be open to any member of the Board.

Defects in Administration

15. The Board shall be responsible for bringing to the notice of the Director-General any defects in the administration of the Centre, any neglect with regard to the welfare of any resident or any breach or non-observance of these Rules.

Recommendations by Board

16. The Board may make recommendations to the Director-General on any matter relating to the Centre. The Director-General shall, if the Board so requests, forward any such recommendations to the Minister.

Records of comments of Board

17. Members of the Board may record their comments in a book specially kept by the Principal, who shall include all such comments in his monthly report.

Part IV

Responsibilities of Director-General

Number of Residents

18. The Director-General shall fix the total number of residents to be accommodated in a Centre at any time and such number shall not be exceeded without his prior permission.

Director-General to make visits

19. The Director-General shall ensure by visits and inspection that each Centre is administered in accordance with these Rules and shall take into account any recommendations by the Board under Rules 15 and 16 of these Rules.

Director-General to appoint visiting Psychiatrist

20. The Director-General may, after consultation with the Director-General of Medical Services, appoint a visiting Psychiatrist for every Centre.

Copy of Rules to be supplied to members of Board and staff

21. The Director-General shall ensure that a copy of these Rules is given to every member of the Board on appointment and to the Principal and to such to such other members of the staff as he may deem necessary.

Director-General to Determine duties of staff

22. The Director-General shall determine the duties of the Principal and other staff of the Centre.

Power of Director-General to delegate responsibilities

23. The Director-General may delegate in writing the exercise of any or all of the powers and duties conferred or imposed on him by these Rules to any officer as he may deem fit.

Part V

Responsibilities of Principal

Management of Centre

24. (1) The Principal of a Centre shall be responsible to the Director-General for the efficient conduct, management and discipline of the Centre under his charge and for all the property thereof and for such other services as are carried on in the Centre.

(2) He shall exercise close and constant supervision over the Centre, having special regard to health, treatment, and welfare of the residents, the sanitation and cleanliness of the premises.

Duties of Principal

25. In the exercise of his responsibilities the Principal shall:

(a) inspect daily every part of the Centre in which residents are accommodated, employed or in training;

(b) visit residents confined to sick bay, in hospital, or otherwise segregated;

(c) tour of the Centre during the night, at varying times and intervals of not less than thrice a week, to satisfy himself as to the state of the Centre;

(d) hear and determine complaints or requests made by residents in the Centre and inform the Director-General of any request which may have been made by a resident for a personal interview with the Director-General;

(e) interview every resident immediately on admission to the centre and also immediately prior to his placing out or discharge therefrom;

(f) inform the parent or guardian of a resident of his arrival at the Centre as soon as possible after admission;

(g) report the death, serious illness, or injury or infectious disease of any resident to the parent or guardian concerned, the Director-General, Director and the Chairman of the Board;

(h) notify the police, Director-General and Director immediately of any violent or sudden death of a resident; and send without delay to the Director-General a report of any inquest relating thereto.

Principal's Monthly Report

26. The Principal shall prepare a monthly report which shall include copies of comments made by members of the Board and details of admissions, discharges, and abscondences. This report shall be placed before the Board at its next meeting.

Daily duties of staff.

27. The Principal shall determine the daily duties of members of the staff.

Delegation of powers and duties of Principal

28. (1) Any power conferred or duty imposed on the Principal may be exercised and performed by a member of the staff appointed to exercise the functions of the Principal during the Principal's absence.

(2) The Principal may, subject to the approval of the Director-General, delegate to any senior and experienced member of the staff any of the duties imposed upon him by these Rules.

Principal to obtain leave of absence

29. The Principal shall obtain the consent of the Director if he wishes to be absent from the Centre for more than 24 hours and shall ensure that arrangements satisfactory to the Director are made for the conduct of the Centre during his absence.

Fire Precaution

30. (1) The Principal shall draw up fire precaution rules and fire drill procedures on the advice of the Chief Inspector of Fire Services and shall ensure that the appliances for the extinction of fire are at all times kept in order and ready for use, and through regular practices all staff and residents are conversant with fire procedure.

(2) A record shall be kept of all practices.

Part VI

Responsibilities of the Medical Officer

Medical examination and Treatment

31. The Medical Officer of the Centre shall carry out:-

(a) a thorough medical examination of each resident on admission, and shortly before leaving the Centre;

(b) a quarterly medical examination of each resident;

(c) frequent inspection of the Centre from a hygienic point of view;

(d) the examination and treatment of residents and members of the staff entitled to medical treatment;

(e) the keeping of medical records in the form and manner approved by the Director-General of Medical Services;

(f) the furnishing of such reports and certificates as the Director-General may require;

Medical treatment in hospital

32. (1) Where in the opinion of the Medical Officer, a resident requires treatment in a hospital or specialised institution, arrangements shall be made for the resident to be received or detained in a hospital or specialised institution for such period as may be necessary. During the period of such detention the resident shall be deemed to be under the care of the Principal.

Surgical Operation

(2) Where a surgical operation is considered necessary and urgent, and the consent of the parent or guardian as required by the hospital authorities is not obtainable within the time available, the Principal shall sign the consent for and on behalf of the parent or guardian.

Part VIII

Responsibility of Staff

Staff to conform to Rules

33. Every member of the staff shall conform with the Rules and regulations of the Centre and shall support the Principal in the administration thereof.

Staff to comply with instructions of Principal

34. All staff shall obey the lawful instructions of the Principal.

No absence without approval of Principal

35. No staff shall leave the Centre premises while on duty without the approval of the Principal.

No borrowing or lending from residents

36. No member of the staff shall borrow from or lend money to any resident. Neither shall any member of the staff accept gifts in cash or kind from any resident.

No supply of administration or prohibited drug to residents.

37. (1) No member of the staff shall supply or administer or be an agent for supplying or administrating any prohibited or unauthorised drug, or equipment for the administration of such drug to any resident.

(2) Any staff who has knowledge of the existence of any prohibited or unauthorised drug or equipment in the Centre shall immediately report the fact to the Principal.

Part VIII

Responsibilities and Privileges of Residents

Residents to comply with Rules and lawful orders

38 Every resident shall comply with all the Rules of the Centre, and shall cooperate with and obey all lawful orders of the Centre staff, including submission to a search of his person and possessions whenever necesary as instructed by the Principal.

Residents to submit to treatment.

39. Every resident shall submit to all medical and other treatment prescribed for his rehabilitation.

Prohibited or unauthorised drug

40. No resident shall possess, smoke, drink, ingest, inhale, push, supply, give, dispense or administer any prohibited or unauthorised drug or possess any equipment fit or intended for the smoking, consumption, administering, injecting or ingesting of such drug.

Leave

41. No resident shall leave the Centre without the approval of the Principal.

No violence

42. Residents shall not resort to any form of violence. A resident will be held responsible and he or his parent/guardian may be liable to pay for any act of his, leading to damage to property or endangering the lives of either residents or staff of the Centre.

No food, etc. allowed into Centre.

43. No resident is allowed to bring any form of food or beverage, liquor, spirits, tobacco or cigarettes into the Centre.

Development of rapport

44. All residents are expected to develop rapport among themselves as part of the resocialisation required in their rehabilitation.

Privileges

45. Residents who have reached the required Grades may be:-

(a) allowed to go out of the Centre on leave;

(b) considered for appointment as Prefects or Deputy Prefects;

(c) considered for discharge.

Earnings

46. (1) In the case of activities in the Centre initiated and financed by the Board, the residents may be allowed to retain earnings as approved by the Board. A savings account may be opened for each resident subject to such conditions as may be imposed by the Director-General.

(2) No resident shall be employed in such a way as to impair his capacity for or to deprive him of reasonable recreation and leisure.

Part IX

Records to be maintained

Maintenance of records

47. (1) The Principal shall ensure that the following records are maintained:

(a) a register of admissions and discharges in which shall be recorded all admissions, orders of detention, revocations of orders of detention and discharges;

(b) a case history of each resident;

(c) a log book in which shall be entered every event of importance connected with the Centre;

(d) a record of all disciplinary proceedings and enquiries held by the Principal which shall include relevant details of such proceedings and enquiries;

(e) a daily register of the presence or absence of each resident;

(f) a punishment book;

(g) separate books of comments for use by members of the Board and officers of the Social Welfare Department and for other visitors;

(h) a register of all gifts presented by the public for use in the Centre provided that gifts in the form of money shall be received and recorded by the Treasurer in accordance with Rules 11 and 12;

(i) an account of all materials purchased for use in the workshop and the disposal thereof;

(j) a record of all articles manufactured in the Centre and of all sales of such articles;

(k) inventories of all property in the Centre in accordance with Treasury Instructions relating to such inventories or in accordance with such direction as may from time to time be issued by the Director-General;

(l) a Cash Book, a Ledger with a separate account for each resident, and a register of National Savings Bank Accounts;

(m) a Property Book for the residents wherein shall be recorded every possession and its approximate monetary value brought into the Centre by a resident. A copy of these particulars shall be kept in the resident's case paper. On the discharge of the resident the method of disposal of each item shall be recorded; and

(n) such other records as may be required under these Rules or on the instructions of the Director-General.

(2) All such records shall be available for inspection by the Director-General or his representative.

Part X

Organisation of Centre

House System

48. Each Centre shall be organised on the basis of a "House" System. The Houses shall be classified according to age and treatment needs of the residents and each House shall have:

(a) a name;
(b) not more than 20 residents at any one time;
(c) a Housemaster in charge;
(d) a Prefect and one Deputy Prefect appointed from those who have shown progress in the programme. Their duties shall be determined by the respective Housemaster.

Domestic maintenance

49. (1) All domestic and compound chores shall be done by the residents and use also as a means of therapeutic treatment. All work required done, shall be graded to correspond with the Grades as decided under Rule 50.

(2) Residents shall perform the work appropriate to their Grades.

Merit System

50. (1) The Centre shall be run on a merit system,with the use of Grades. These Grades shall be decided by a Committee established by the Principal for the purpose of determining:

(a) the tasks and chores for each grade;

(b) the privileges for each grade;

(c) the factors to be taken into consideration for the upgrading or downgrading of any resident;

(d) the regularity of grading.

(2) The Committee will review the grading system regularly.

Part XI

Admission

Admission of resident

51. (1) No person shall be admitted to a Centre except in accordance with the provisions of Part VA of the Dangerous Drugs Ordinance and any other existing law.

(2)(a) Every person seeking admission of his own free will, shall prior to admission, execute a personal bond as prescribed in Schedule II.

(b) In the case of a minor his lawful guardian shall be required to execute a personal bond on his behalf as prescribed in Schedule III.

(3) Every resident shall be searched on admission in a manner consistent with the necessity for revealing any concealed article.

(4) A female shall be searched only by a female member of the staff

Property of resident

52 (1) All monies, documents, jewellery, clothing or other personal effects belonging to a resident which are not allowed to be retained by him shall be placed in the custody of the Principal who shall keep an inventory thereof in the Property Book which shall be authenticated by the resident concerned and the Principal and witnessed by a member of the staff.

(2) All valuables and cash shall be kept in the safe provided.

(3) Such monies, documents, jewellery, clothing or other personal effects kept in custody under (1) shall be returned to the resident concerned on his discharge from the Centre.

New residents to be acquainted with responsibilities and privileges

53. (1) The Principal shall acquaint every resident on admission, with the objectives of the Centre, his responsibilities and privileges and assign him to a House. If necessary the resident may be reassigned later to another House more suited to his needs.

(2) On being assigned to a House, the Housemasters shall detail a senior redsident to help the new resident to settle in.

Part XII

Care of Residents

Separate beds

54. Every resident shall be provided with a separate bed.

55. (1) Every resident shall be supplied with sufficient and varied food based on a dietary scale approved by the Director-General, which shall include a list of dishes and quantities to be supplied to each resident.

(2) Proper arrangements shall be made for the preparation, cooking and serving of diets as required by custom and religion.

(3) A copy of the dietary scale and menu shall be kept posted in the kitchen and office of the Centre.

Religious Instruction

56. Religious instruction and facilities for religious observance shall be provided for all Muslim residents. For non-Muslim residents assistance for religious observance and instruction shall be arranged according to their religious persuation.

Part XIII

Recreation, Visits, Leave and Letters

Recreation

57. Adequate provision shall be made for free time and recreation, including organised games.

Visitors

58. (1) New residents shall not be ordinarily allowed any visitor for the first two weeks of their stay in the Centre.

(2) Visitors are ordinarily restricted to immediate members of the family.

(3) Visitors may be required to submit to a search.

(4) Visitors are not allowed to bring any form of food, beverage, liquor, spirit, tobacco or cigarettes into the Centre

(5) No visitor shall be allowed into the sleeping area at any time.

Leave

59. Leave may be granted to a resident unless circumstances make it impracticable or undesirable.

Provided that leave shall not be granted in excess of seven days during his period of stay, and shall not ordinarily be granted in the first three months of the period of residence.

Correspondence and visits

60. (1) Every resident shall be encouraged to write to his parents or guardian at least once a month, and he shall be allowed to receive letters from parents, guardians, relatives and friends at such reasonable intervals as the Principal may determine unless circumstances make it impracticable or undesirable. For this purpose postage stamps may be provided.

(2) Every letter to or from a resident shall be read by the Principal or by a responsible officer deputed by him for that purpose and it shall be at the discretion of the Principal to impound any letter if he considers its contents objectionable.

Suspension of privileges

61. The Principal may suspend any of these privileges if he is satisfied that they interfere with or are likey to interfere with the discipline of the Centre. Any such suspension shall be recorded in the log book.

Part XIV

Daily Programme of Activities

Daily time-table

62. (1) The daily time-table of every Centre, including the hours of rising, classroom instruction and practical training, domestic work, meals, recreation and retiring, shall be approved by the Director-General.

(2) A copy of the daily time-table shall be posted in a conspicuous place in the Centre and in the general office.

(3) Any substantial deviation from the daily time-table shall be entered in the log book and a notification thereof shall be sent forthwith to the Director-General.

Part XV

Unauthorised Absence and Escape

Unauthorised absence and escape

63. The Principal shall report within twenty-four hours any unauthorised absence or escape of any resident to the Director General, the police, the Director and Social Welfare Officer of the area in which the resident lives, the parent or guardian and the Chairman of the Board.

Part XVI

Discipline and Punishment

Discipline

64. The discipline of the Centre shall be maintained by the personal influence of the Principal and staff and shall be promoted by a system of rewards and privileges.

Punishment

65. When punishment is necessary for the maintenance of discipline one of the following methods shall be adopted:

(a) forfeiture of rewards or privileges (including earnings) or suspension from games and recreation;

(b) extra work of a kind suitable to the resident but not of such nature or duration as to be injurious to health;

(c) segregation from other residents;

Provided that this form of punishment shall only be used in exceptional cases and subject to the following conditions:

(i) no resident under the age of twelve shall be kept in segregation;

(ii) the room used for this purpose shall be accessible to light and well-ventilated, and shall be kept lighted after dark should the resident so request;

(iii) some form of occupation shall be given;

(iv) communication with a member of the staff shall be provided for, and the resident shall be visited by a member of the staff at intervals not exceeding three hours;

(v) segregation shall not be continued beyond twenty four hours without the written consent of the Director-General;

Punishment book

66. (1) The Principal shall be responsible for the immediate recording of any punishment in the punishment book kept under rule 47 (f) and shall enter such particulars as may be required by the Director- General.

(2) The punishment book shall be examined at each meeting of the Board and shall be signed by the Chairman or the member presiding. It shall be available for inspection at all times by the Director-General.

No Corporal or humiliating punishment to be inflicted

67. (1) No member of the staff shall inflict any form of corporal or humiliating punishment, including striking, punching, slapping, cuffing, shaking or any other form of physical violence on any resident.

(2) Any member of the staff who commits a breach of this rule shall render himself liable to disciplinary action.

Part XVII

Review of Cases, Discharge and Aftercare

Discharge

68. The Board shall approve all discharges from the Centre.

Quarterly Progress Report

69. (1) The Principal shall prepare a quarterly progress report on each resident including his home situation for review by the Board.

(2) At each review the Board shall consider the date on which the resident is thought fit to be discharged.

(3) Where the Board is of the opinion that a resident should be discharged in the first four months of his residence it shall furnish a report to the Minister for his approval.

(4) The Board shall maintain a review and discharge register showing the date and result of its review of each case and the reasons for its decisions.

Aftercare

70. (1) Arrangements for discharge shall be made after consultation with the Social Welfare Officer or any person responsible for his aftercare who shall be given all relevant information and assistance necessary in securing the continued and well directed aftercare of the resident.

(2) An aftercare order granted in accordance with these Rules shall be in such form and subject to such conditions as may be prescribed by the Board in Schedule IV.

Part XVIII

Miscellaneous

Deletion, variation and addition to Schedule I

71. The Minister may at any time by direction delete from, vary and add any Rehabilitation Centre to the list in Schedule I.

Suspension of Rules

72. The Minister may from time to time suspend the application of any part of these Rules to any Centre until such time and on such conditions as may be specified in the notice to the Principal.

Dated this day of , 197.....

Minister of Welfare Services

MINISTRY OF WELFARE SERVICES MALAYSIA

Preventive Services Statistics of Drug Dependants Cases from 1.10.1975 - 31.3.1978

1. **Number of Cases Referred to the Department of Social Welfare**

(a) **By State**

State	Male	Female	Total
Perlis	12	—	42
Kedah	195	1	196
Pulau Pinang	376	3	379
Perak	1,118	2	1,120
Selangor	894	14	908
W. Persokutuan	1,087	17	1,104
N. Sembilan	230	3	233
Melaka	173	10	183
Johor	598	8	606
Pahang	134	—	134
Trengganu	58	—	58
Kelantan	194	10	204
Total	5,099	68	5,167

(b) **Drug Abused**

Drug	Male	Female	Total	Percentages (%)
Cannabis	165	4	169	3.27
Opium	93	—	93	1.79
Morphine	445	5	450	8.70
Heroin	3,939	42	3,981	77.04
Amphetamine	20	1	21	0.40
M. X. Pills	5	1	6	0.11
Barbiturates	15	—	15	0.29
Poly Drugs	373	15	388	7.50
Others	19	—	19	0.36
Not yet ascertained	25	—	25	0.48
Total	5,099	68	5,167	

2. **Cases Under "Supervision" at the end of March, 1978.**

(a) **By Age Group**

Age Group	Male	Female	Total
Under 12 years	—	—	—
12 to 15 years	12	1	13
15+ to 18 years	66	5	71
18+ to 21 years	467	10	477
21+ to 30 years	394	6	400
30+ to 40 years	22	—	22
40 and above	4	—	4
Total	965	22	987

(b) **By State**

State	Male	Female	Total
Perlis	—	—	—
Kedah	66	—	66
Pulau Pinang	—	—	—
Perak	24	—	24
Selangor	—	—	—
W. Persekutuan	595	12	607
N. Sembilan	4	1	5
Melaka	17	—	17
Johor	124	1	125
Pahang	—	—	—
Trengganu	9	—	9
Kelantun	126	8	134
Total	965	22	987

3. **Cases under "after care" at the end of March 1978**

(a) **By Age Group**

Age Group	Male	Female	Total
Under 12 years	—	—	—
to 15 years	—	—	—
to 18 years	70	—	70
to 21 years	259	—	259
to 30 years	479	2	481
to 40 years	40	—	40
and above	5	—	5
Total	853	2	855

(b) **By State**

State	Male	Female	Total
Perlis	9	—	9
Kedah	28	—	28
Pulau Pinang	84	—	84
Perak	83	—	83
Selangor	266	2	268
W. Persekutuan	249	—	249
N. Sembilan	44	—	44
Melaka	23	—	23
Johor	31	—	31
Pahang	23	—	23
Trengganu	3	—	3
Kelantan	10	—	10
Total	855	2	855

4. Total cases - supervision and aftercare at the end of March 1978

Male	Female	Total
1,818	24	1,842

DANGEROUS DRUGS ORDINANCE 1952

REHABILITATION COMMITTEE (CONSTITUTION AND DUTIES) REGULATIONS 1977*

30/52 In exercise of the powers conferred by section 25-0 of the Dangerous Drugs Ordinance 1952, the Minister makes the following regulations:-

Citation. 1. These regulations may be cited as the Dangerous Drugs Ordinance (Constitution and Duties) Regulations, 1977.

Interpretation 2. In these regulations unless the context otherwise requires:-

"Committee" means a Rehabilitation Committee;

"Minister" means the Minister of Welfare Services.

Membership of Committee 3. (1) A Committee shall consist of not less than seven members of whom at least two shall be women and at least two shall be men.

(2) In addition to the members falling under paragraph (1) a social welfare officer for the state or district for which a Committee is appointed to be designated by the Director of Social Welfare for the State concerned, shall also be a member of the Committee.

(3) The appointment of a member falling under paragraph (1) shall be for a term not exceeding three years, but any such member may be reappointed at the discretion of the Minister.

(4) In the absence on leave of the social welfare officer, any of his assistants designated by him shall attend meetings of the Committee as a member thereof.

Removal and resignation 4. (1) The Minister may at any time, if he thinks it expedient to do so, revoke the appointment of any member of a Committee falling under regulation 3 (1) without assigning any reason therefor, and any such member may at any time resign from a Committee.

(2) The Minister may appoint another person in place of any member whose appointment is revoked or who has resigned, and may at any time make additional appointments to a Committee.

Chairman 5. The Chairman of a Committee shall be appointed by the Minister from among its members.

Officers 6. (1) Each Committee shall elect a Secretary and a Treasurer from among its members.

(2) No member of the staff of the Department of Social Welfare shall be eligible for appointment as Treasurer.

(3) The Secretary shall inform the Minister of any vacancy arising in the Committee by reason or death of resignation or from any other cause.

Meetings 7. (1) A Committee shall meet as far as practicable once a month, but it shall meet at least once in every three months.

(2) The Chairman or, in his absence, a member of the Committee elected by the members present shall preside over a meeting.

(3) Three members of the Committee shall for a quorum.

(4) All questions arising at any meeting shall be decided by a majority of votes, each member present being entitled to one vote, but in the case of an equality of votes the Chairman or the member presiding shall have a casting vote.

Committee

8. A Committee may appoint such sub-committee as it thinks necessary, with specified terms of reference for the efficient performance of their duties.

Duties

9. (1) The duties of a Committee shall be:-

(a) to assist social welfare officers in the supervision and aftercare of drug dependants including those discharged from rehabilitation centres;

(b) to assist social welfare officers in securing training and employment for their supervisees;

(c) to encourage community participation in the prevention of drug abuse and in the rehabilitation of drug dependants particularly in regard to their reintegration into society;

(d) to make recommendations to the Director General of Social Welfare on any possible need for policy or legislative changes in respect of preventive and rehabilitative measures in drug abuse.

(2) In performing its duties a Committee shall act in accordance with, any advice or guidance, consistent with the duties of the Committee, that may be issued by the Director General of Social Welfare.

Secretary

10. The Secretary shall carry out the directions of the Committee and shall keep minutes of its proceedings and shall forward copies thereof to every member of the Committee and to the State Director of Social Welfare and the Director General of Social Welfare as soon as possible after the meeting to which they relate.

Treasurer

11. The Treasurer shall keep proper accounts and records of the funds operated by the Committee and of all its income and expenditure, and shall lay before the Committee its statement of accounts for each calendar year, as soon as possible after the accounts have been audited by auditors appointed by the Committee with the approval of the State Director of Social Welfare.

Minister of Welfare Services

*Subject to amendment

INSTITUTIONAL REHABILITATION OF DRUG DEPENDENTS IN MALAYSIA

By

Yip Peng Low

Principal, Drug Rehabilitation Centre
Kuala Kuba Baru, Malaysia

This paper attempts to illustrate the rehabilitation programme that a drug dependant undergoes during his six-month stay at a drug rehabilitation centre in Malaysia.

Presently, there are three drug rehabilitation centres in Malaysia, sponsored by the Ministry of Welfare Services. They have been entrusted by law to establish and administer a rehabilitation programme for drug dependants.

As a result of a joint decision between the Ministry of Welfare Services and the Ministry of Health, a crash programme was begun in October, 1975. The Ministry of Health was to provide detection and detoxification centres, and the Ministry of Welfare Services was to establish rehabilitation centres. However, new legislation effective 15 November 1977, has made detoxification centres the responsibility of the Ministry of Welfare Services, which is now establishing new comprehensive drug centres under the current Third Malaysia Plan.

Before I touch on the rehabilitation programmes initiated in the drug rehabilitation centres, it might be worthwhile here to give you a very brief picture as to how drug dependants find their way into drug rehabilitation centres for rehabilitation.

Legal Framework

Drug dependants admitted to drug rehabilitation centres are normally committed by the Courts under the provisions of the Dangerous Drugs (Amendment) Act 1977 and the Dangerous Drugs (Amendment) (No. 3) Act 1977, which became effective from 15 November 1977. These drug dependants may be classified under three broad categories:

a) The suspected drug dependant;
b) The drug dependant convicted of an offence under the Dangerous Drugs Ordinance;
c) The volunteer drug dependant.

a) The suspected drug dependant is first identified by a police officer not below the rank of Sergeant or a Social Welfare Officer and brought before a Magistrate for remand to a detection centre. If he is medically certified to be a drug dependant, and upon the recommendation by a Social Welfare Officer in his report, he may be committed by the Court

to a rehabilitation centre for six months. However, there is provision in the law for the Court to place him, instead, under the supervision of a Social Welfare Officer for a period of two years, provided he enters into a bond of good behaviour.

b) The drug dependant convicted of a criminal offence who is under the age of 21, as outlined in the Dangerous Drugs Ordinance may, if he receives a favourable report by the Social Welfare Officer, be committed by the Court to a rehabilitation centre for six months. Here again, as an alternative, the Court has the authority to release him on probation for a period of two years with or without Court conviction, on the condition that he enters into a bond of good behaviour. However, if the Court finds it inappropriate to send him to a rehabilitation centre or issue him a probation order, it may alternatively send the offender to prison or impose a fine, or both.

c) The adult drug dependant may voluntarily apply to the Social Welfare Officer for admission to a rehabilitation centre. In the case of a minor, his parent or guardian may make such application on his behalf with or without his consent for treatment and rehabilitation. Before he can be admitted, the volunteer must be certified as a drug dependant by a Government doctor at a detection centre and must comply to certain terms and conditions governing his admission. The Social Welfare Officer submits his report to the Magistrate who then issues the order for rehabilitation. Once admitted to a centre, he is treated the same as any other resident, as if, instead of volunteering, he had been apprehended and compelled by Court action. Thus, should he absent himself from his centre without lawful excuse, his act becomes an offence against the Dangerous Drugs Act.

MODERN CONCEPTS OF REHABILITATION

As is known from case studies, drug dependancy frequently follows unhappy circumstances in the home. These negative influences also manifest themselves in inadequate personality development, anti-social behaviour, low self-esteem, and an inability to cope with the stresses of everyday life. The individual gradually develops a physical and psychological dependency on drugs to enable him to face what seems like insurmountable social pressures. Based on this understanding of the drug abuser's problems, Malaysia has designed its rehabilitation programme on the assumption that the drug dependant person requires help rather than punishment. Therefore, it is the aim of our drug rehabilitation centres to provide treatment for those who are regarded as sick, rather than punishment for those who are seen as criminals.

This attitude is meant to underlie all the subsequent decisions affecting policy, procedure and person-to-person interaction. Dependants tend to be defensive, wary, and untrusting. Yet, it is basic to their treatment, that they come to perceive the programme as an attempt to help them, that they feel themselves in the trustworthy hands of a benevolent authority. At times, the workings of our own system seems to make the task of

rehabilitation more difficult. The Police and the Courts are involved in apprehension, identification, and compulsory assignment to centres. Even when a young dependant voluntarily turns himself in to a Social Welfare Officer in an act of sincere good faith, he is nevertheless required by law to be remanded for rehabilitation by a Magistrate. It cannot be expected in such circumstances to avoid completely the punitive overtones of a sentencing.

THE REHABILITATION PROGRAMME

The rehabilitation process is designed to help the drug dependant become physically healthier, mentally more alert, socially more appropriate, and emotionally more stable than he was when admitted. It is also expected that, to the extent these goals are achieved, he will, upon return to his home, bring with him enough resolve and determination to lead a drug-free life thereafter. To achieve its goals, the rehabilitation programme focuses on the following:

a) Physical Restoration

Habitual drug abuse characteristically results in the physical deterioration of the individual. Not only does it cause him to neglect his personal appearance, but it often leaves him emaciated and sickly. At the time of entry into the rehabilitation process, the body of the drug dependant is still under the influence of residual drugs in his system. Therefore, the first step is a thorough detoxification under medical supervision. This is followed up, or accompanied by, treatment of the various illness such as venereal diseases which they also have commonly contracted. This process usually takes two weeks or longer to ensure a drug-free, disease-free transfer to the residential areas of the rehabilitation centres.

As soon as he is transferred, the drug dpendant is interviewed by the Principal or his Deputy who explains the rules and regulations. He then undergoes a special initiation or welcoming orientation conducted by senior residents wherein he is required, without much ceremony, to describe honestly and in detail how drugs have affected his life. The group knows only too well how drug dependants tend to avoid the truth, and they know all the tricks. Experience has shown that this unofficial device very quickly convinces the new arrival that his stay is not meant to be a picnic.

As soon as possible after admission, each new resident is given a very short haircut, assigned to his house and bed, and issued clothing. His excess personal belongings are put into safe storage. He then is ready to begin the daily routine of varied physical calisthenics, exercises, and sports activities. Unless excused by the medical officer, every resident undergoes a 45-minute period of rigorous physical exercise under the direction of a senior resident. This is done at 6.00 a. m. every day, and those who are unfit for strenuous activity are not completely exempted, but are required to perform more moderate exercises. In addition, the residents are given military drills twice weekly by volunteer Army physical instructors. This serves to enhance their sense of discipline and co-operative

activity. It also stimulates feelings of pride, accomplishment, and mutual participation as they see themselves performing with ever-increasing skill and precision. At one of the centres, for those who are enthusiastic about callisthenics, gymnastic classes are offered three evenings a week under the direction of a paid, part-time instructor. Where possible, residents are encouraged to involve themselves in the making of their own gymnastic equipment which also affords them an important sense of contribution and achievement.

Food at the centres is specially selected and prepared to provide a nutritious, balanced diet. It soon becomes quite evident that the run-down bodies respond well to this rigorous daily programme of good food, regular hours, fresh air and sunshine, and supervised exercise. It is interesting to note that residents of only a few weeks report the re-awakening of dulled appetites, intellectual and sexual, as well as nutritional.

b) Moral Guidance and Religious Instruction

Behind all the other rehabilitation efforts, is the centres' policy of consistent guidance back toward moral and religious influences. Each resident is provided with the necessary time, place, and leadership to help him re-establish close, regular contact with his beliefs. It is felt that this is an important part of the overall process. Muslim residents are encouraged to pray five times each day as required under their religion. They arise as early as 5.30 a.m. for their first prayer in the prayer house located inside the centres. They also receive religious instruction from paid, qualified religious teachers appointed by the Religious Affairs Department. These instructions are given four times a week and as many Muslim residents as possible are encouraged to join local inhabitants for Friday prayers in the town mosque. For example, at Kuala Kubu Baru, the military provides free transport and the centre provides escort for our residents, to discourage them from yielding to the temptation to obtain cigarettes or run away.

For residents of other religious beliefs, special arrangements are also made. Local church leaders conduct Bible classes three times each week for residents of Christian faith. Last Christmas Eve, the members of the Bible class at Kuala Kubu Baru were allowed to attend church and were invited to go carolling at staff quarters within the centre. Hindu and Buddhist classes are also conducted at least once a week by voluntary religious organizations.

Although all residents do not respond the same way to religious guidance, a significant number seem to benefit. Recently a surprised and and appreciative father told me that his son, while home on leave, chose of his own free will to continue his re-established practice of daily prayer. He said that the boy showed new self-respect because of this. It is also possible that this encouragement back to religious ways allows the dependants to resolve a rather subtle psychological problem. Many may harbour a heavy guilt for their deviation from the more normal ways of life, and for the pain and hardship they may have inflicted on their loved ones.

They may have lost all hope of forgiveness, which would help justify staying on drugs. At the centre, those who need such new hope often find it when they are guided back to more moral practices. It is as if we are saying, "Yes, you can be forgiven."

c) Vocational and Recreational Therapy

To help the new residents free themselves from the unruly, anti-social habits and behaviour that frequently accompany the drug abusive life, the first month at the centres is purposely very strict, very intense, and tightly structured. This tactic generally succeeds in helping the new resident through a difficult period of adjustment to the relatively structured life in the centres. It also serves to occupy their time and thoughts so that they do not dwell on drugs and other anti-therapeutic ideas. It also helps them to form good habits and to develop self discipline. All new arrivals are subjected to a special rigorous programme of vegetable gardening, grounds maintenance, and other outdoor agricultural work. After a certain amount of time, those who show an interest in learning new skills are encouraged to join the vocational classes in carpentry, book-binding, welding, and rattan furniture making. The developing skills of the residents are frequently tapped and made use of according to the needs of each facility. The entire structure, which houses the welding workshop in the Beckit Mertajam Centre, was constructed entirely by residents, a few of whom are skilled carpenters and masons. In all the centres residents help maintain the physical plant by making needed repairs, painting, landscaping and constructing simple pieces of furniture.

Recently, the centre at Kuala Kubu Baru was awarded a contract to bind all the journals and other periodicals of the local Court. Negotiations with the State Library are currently under way to repair damaged books and magazines. Not the least of these gratifying new developments is the fact that the residents who work in the book-binding shop are being trained by none other than an ex-drug dependant who has just been put on the Ministry payroll. The potential here is exciting to contemplate.

The rattan furniture workshop at Kuala Kubu Baru was introduced just two months ago with one paid instructor and six totally unskilled residents. Today, there are fourteen workers of varying levels of skill and their furniture pieces are in great demand by members of the staff and local residents. The most recent development occurred when a large cane furniture manufacturer offered to contract with the centre for several thousand rattan chair parts to be produced for export to Australia, New Zealand, and other countries. This, of course, has greatly enthused many residents. One of them, seen to be eligible for discharge, requested, on his own volition, that he remain longer so that he might acquire and develop further skills. We are attempting to arrange for him to enroll at some handicraft training centre to develop his newlyfound abilities enough to have him eventually return to us as a full-time paid instructor. We are learning that our workshops are capable of yielding profits. We are also discovering that some of the profits can be worth more than just money.

Vocational activities are also important psychologically. Some of the residents become quite skilful and develop new self respect because of their learned skills. For those who already have employment waiting for them, these activities serve to occupy their time in constructive ways, and help them develop working habits and a cooperative attitude. For others, such work helps them feel better prepared to follow new avenues of possible employment after they leave the centres. It also instils in them a certain productive momentum which can support them upon their re-entry into everyday life in their home communities. It is expected that they will have become accustomed to working on a daily basis in a careful and responsible manner.

In addition, various games and competitive sports among residents themselves and against local teams are included as part of the regular recreational activities. Those with musical talents are encouraged and aided in their efforts to organize musical groups. Certain musical instruments are provided within our budgetary limits, as are assorted supplies and equipment for those who show interest in art, or handicrafts such as wood carving, copper tooling, etc. Reading materials and daily newspapers and periodicals, as well as television and occasional cinema viewings are made available to the residents both for creative pleasure and leisure-time recreation. Once a week a limited number of residents are taken to a local swimming pool for an enjoyable swim.

d) **Psychological Services**

After two years of practical rehabilitation experience, many Social Welfare Officers have come to believe that psychological aspects of drug addiction hold the key to more effective and permanent cure. Every interaction between Social Welfare personnel and dependants can help or hinder the over-all process. Therefore, it is becoming clear that special therapeutic skills, interviewing techniques, and a deep grasp of human psychological development needs to be part of the professionals' expertise. At the present time regularly scheduled group and individual counselling sessions are provided for all residents. When requested, time for additional individual sessions with Case Workers and other staff members are also provided. Currently, trained Clinical Psychologists are being sought to effectively improve the intensity of psychological treatment. Some of the projected programmes include classes in self understanding, introduction to concepts of mental health, individual differences, and personality traits. In addition, training programmes in this field are being developed to help all members of the rehabilitation staff to attain more effective methods of working with drug dependant persons. Eventually, it is intended that such psychological expertise will penetrate all aspects of the rehabilitation programme, beginning with public education and extending all the way through the two-year mandatory after-care programme.

This growing interest in psychological aspects is making us look more closely at what transpires in counselling sessions. Although every counsellor necessarily works in his own way, the verbal interaction that customarily takes place seems to fall naturally into these general categories:

a) Airing of personal problems;

b) Confronting other residents;

c) Discussing topics of mutual interest.

These areas make up an important part of the rehabilitant's counselling experience. Open revelation of the various personal concerns on the minds of counsellees not only helps to unburden them and avail them of professional guidance, it also awakens in them and in the others in their counselling groups a fresh awareness of the common, human struggles they all share. To the extent that these young men have been feeling somewhat less than human and strained by their addiction, airing their personal concerns in a sympathetic environment can help form a nucleus for new hope and resolution. Personal confrontation within a permissive atmosphere seems to be a good device for releasing some of the emotions that must be stirred up when so many are confined together for so long a time. This is part of a larger process wherein residents learn through daily experience how to deal with life's frustrations without relying on drugs. Discussions about selected topics are planned and conducted by Counsellors to coincide with the residents' progress through the centre. For groups of newcomers, the topics aim at a deeper understanding of the various roads to addiction. In the latter weeks of their stay, seniors talk about the difficulties of their forthcoming re-entry into society. Between these times equally pertinent material is brought up, examined and carefully considered. All this is important to the rehabilitation process. But many officers believe it is not enough.

First of all, it is felt that the necessary motivation to change, the desire to become cured no matter what it takes, is not automatically contained within the breast of every new rehabilitant. In fact, some may have little or no faith in the programme having met and talked to dischargees who fell back on drugs. All are affected to varying degrees by what seems like a natural resistance to change, a phenomenon familiar to all psychotherapists. It is, therefore, believed that a degree of counselling skill is called for that surpasses the usually competent level attained by trained welfare personnel. Some of the expertise of the Clinical Psychologist, the Psychotherapist, and the Psychiatrist needs to enter into regular counselling activity. At least enough to motivate those of little faith, to touch the hearts of those hardened by difficult lives, to fortify those who have lived too long in fear, and to bring those who believe their own bravado back closer to more painful reality. These things require more than the usual counselling techniques currently employed in the centres. Of course, our limitations are obvious. We cannot provide hundreds of psychologists and psychotherapists. Nor do we need to. But, what we can do is move as much as possible in directions that make rehabilitation centres into therapeutic communities. We can learn as much as possible from the few who come to train us. We can accept honestly the truths of our limitations and incorporate new ideas in the place of old habits. We owe nothing less to those who come for help, or to ourselves.

e) Drug Rehabilitation Centre Rules and Regulations

According to the Dangerous Drugs (Amendment) Act 1977, the Minister of Social Welfare Services is empowered to draw up rules and regulations for the operation of the drug Rehabilitation Centres. These have led to a consistent pattern of procedures, some of which are as follows:

The residents are graded according to their length of stay in the centre and wear coloured badges that distinguish their grades. They may also be promoted to various ranks of leadership by a grading committee made up of the Principal and members of his staff. The highest rank is that of Prefect, attained by those residents selected on the basis of leadership qualities, over-all character and cooperative attitude. This Prefect system of limited self-government is an important means of helping the administration, as well as the residents themselves deal with various minor problems of discipline, duty assignments, organization of special events, etc. The centres are run on a "house" system by which the residents of each building elect their own leaders who conduct meetings regularly to hear out problems, complaints and suggestions. These are passed on to the Prefects who eventually present them to the administration. When handled with careful judgement, the Prefect system can be an important part of a smoothly functioning centre.

Since residents must be prepared for eventual discharge even as they are undergoing treatment, home leave of about three to five days is made available after three months stay. This serves several purposes. The resident has the time and opportunity to attend to personal affairs, to make contact with family, friends and employer, and not of least importance, to test his ability to avoid the use of drugs. Upon his return, careful urine analysis is used to determine how well he fared in the latter respect. Often, unexpected new problems concerning family, friends, and job will require special attention following home leave.

Care is also taken to ensure that the residents do not attempt to smuggle in drugs when they return from leave. They are also searched on their return as well as the surrounding areas.

An over-all policy of discipline is enforced in order to ensure the smooth running of the centres. Punishment meted out for misconduct or infraction of the rules consists of loss of privileges, extra exercises, or at the extreme, segregation from the other residents. Corporal punishment by the Staff is not permissable.

In addition, the law, however, gives the Board of Visitors, appointed by the Minister of Welfare Services, the discretion to extend the period of rehabilitation from six months to a further period not exceeding six additional months, if it is in the interest of the resident. It can also shorten the period of detention if the resident has completed four months stay in a centre.

Because rehabilitation is compulsory under the law, and because dependants and their friends function under other than therapeutic principles, a certain amount of security is required to keep residents in and drugs out. Centres are surrounded by barbed-wire metal fencing and staffed with guards. Cooperative arrangements are made with the local police and fire departments who are prepared to respond in case of emergency. Within the centre, roll call is taken many times a day. Twice a week, at unannounced times, a number of residents whose names are selected at random, are submitted to urine tests. When visitors arrive (immediate family members may visit residents) care is taken to prevent the smuggling of drugs and cigarettes. Various other devices and methods are employed, but always with as light a hand as possible. Guards do not carry letheal weapons. The front gate is kept open through the day and into early night time. Movement of staff and residents about the centre grounds is casual and relaxed. Although these are places of confinement, the atmosphere carefully de-emphasizes this aspect of the dependants' experience.

f) After-care Services

With the new amendment to the Dangerous Drugs Ordinance 1952, after-care services are being made mandatory for all residents discharged from a centre to undergo a two-year compulsory after-care supervision by a Social Welfare Officer in the field. This law has been implemented since 15 November, 1977. The purpose of the enactment is to give further psychological support to dischargees to face realities in life and to discourage them from falling back on drugs. Any dischargee who commits a breach of the conditions in the after-care order can be recalled to the Centre by the Board of Visitors for further detention for a period not exceeding six months. Since the discharge will be relatively free to decide for himself the extent to which he makes use of after-care services, great care is taken to inform him of locations of half-way houses, day centres, and other community facilities that have been established especially to help him remain drug free and develop a better way of life. To date, such places are far too few to meet the need, but the highest priority is being given to the expansion of these services.

CONCLUSION: ON MEASURING SUCCESS

At first glance,the suitable measure of success of drug rehabilitation programmes seems obvious. One need only divide the number of permanently cured dischargees by the number admitted to derive a percentage of efficiency. But one should not be too quick to adopt so simple a device for this complex problem that, after decades, still challenges the best efforts of the world's most developed societies. Those who strive to understand the innermost workings of human drug addiction soon find themselves confronted by the unsuspected magnitude of their task. To follow with any scientific integrity each implication that stems from this problem, one would be required to re-examine all the social institutions of civilized life and all their innumerable inter-relationships. Within

family and child-rearing practices, within the various professional and technical arts and sciences, within the traditions, beliefs and philosophies of life, the roots of drug addiction have long been implanted.

It is sobering to note that respected thinkers around the world see drug abuse as a common symptom of the unavoidable discontents of civilization evident in all cultures. Perhaps, like crime and prostitution, drug abuse will persist in one way or another, never to be obliterated, at best to be minimized and controlled. In the light of this view, the drug-addicted individual is seen as a symptom of cultural imperfections which, in time, may or may not yield to the ebb and flow of changing social tides. Meanwhile, we who try to rehabilitate are entrusted with the treating of symptoms of serious social maladies without benefit of the complete understanding of their origins and causes. To my knowledge, no nation is yet sure of the precise extent to which drug abuse infects its population. In Malaysia, the best informed authorities estimate for every case of addiction identified, ten others remain undetected. What we all do know is that we are confronted by a most serious problem with deeply entrenched, far-reaching roots - a problem that continues to affect more and more lives every day.

The means of measuring our progress must therefore take into account the complexities of our task. Every newly applied idea that deepens our understanding or sharpens our skill or reduces the flow of drug traffic should be counted as an increment of success. Every cooperative exchange of information and ideas such as we are engaged in today should likewise be so counted.

Malaysia's programme is very young compared to most other countries. It is constantly being scrutinized and evaluated. Officers are continually sent overseas for more advanced training. Foreign experts with significant experience are sought out and invited to contribute to our efforts. Perhaps as important as any other aspect of this endeavour is the work in the field and in the centres themselves. The practical experience of those in direct contact with the dependants in their day-by-day struggle to change their lives is becoming an invaluable source of feed-back to the Ministry. The facts and details of successes and failures, faithfully recorded and accurately reported, will soon serve as a unique compass to guide those responsible for the plotting of future courses.

EX-DRUG DEPENDENTS AS THERAPEUTIC STAFF IN A REHABILITATION PROGRAMME

Presentation of a Paper

By

Encik Yakob bin Abdul Rahman

President, Pusat Pertolongan Batu Gajah
Perak, Malaysia

For many people this issue is very controversial. It is seldom brought out into the open for analysis and discussion.

The reason is perhaps, the sensitivity of the whole affair : this is often aggravated by poor definitions and inadequate understanding of the various terms, or of the roles that are being played.

Let me now deal with the first question, which is the term "Ex drug-dependent".

1) EX-DRUG DEPENDENT - Former Drug User

There seems to be a jungle of definitions of the "Ex drug-dependent" and this causes a lot of confusion. For Pusat Pertolongan's drug rehabilitation programme, the term "Ex-Drug-dependent" is officially used only for "Graduates" who have at least an 18 months period of abstinence from abuse of drugs. We prefer to call them "former drug users". It is true that the so-called "dry period", the period of physical absence of foreign chemical substances in the body, is referred to as an "Ex-addiction" period; but this only concerns his present state of use or absence of use of drugs, and does not indicate any degree of stability.

2) THERAPEUTIC STAFF - Therapist

The second term is equally confusing. While some would like to include on occasion even such people as Adviser, Bomoh, Counsellor, etc. as a therapist, others prefer to keep this definition for the professional, certified and graduated academic who works in the drug field. To argue which and who should be called a therapist is not my aim. I intend rather to look at who is regarded as having a therapeutic role to play.

Even in our organisation, the term "therapist" has many meanings. A therapist basically is a person who contributes to the restoration of health in a person. This is indeed the very purpose of the 'Therapeutic Community'; A Community — a group of people living together, with beneficial and positive influence on one another's behaviour. However we would like to define the term Therapeutic Staff — A therapist — as a person who unlike most people in the group, consciously uses and applies various forms of communication to influence the behaviour of others with a clearly set aim and objective.

I allow that my definition might be vague and I do open myself to questions upon this topic. I believe it is the best I can give within such a brief description.

Now, having defined our terminology and also the term 'Therapeutic Community', we can embark upon the next question, which is the role of former drug users as Therapeutic Staff.

3) Firstly I like to clarify that having a "respectable street" record of drug abuse with all its misery and stealth , does NOT in itself qualify a person to 'teach others'. It is hard for a junkie to become a therapist as it is for a hospital patient to become a practising doctor. Further, an aloof graduate from any respectable Institute of higher learning may not necessarily have the skill and experience to deal with the complexity of drug abusers and drug abuse. Perhaps certain qualifications from both categories are essential for a good therapist. So please note clearly that neither a personal history of drug abuse nor a formal academic training is sufficient to **guarantee** a good therapist.

Nevertheless, you may have a person with a street record who, as a former drug user, turns towards the study of personality, behaviour, and the whole list of subjects which a good therapist needs to know about. Such a person has the great advantages of:-

i) Knowing what he is talking about.
ii) Fulfilling a 'model' role for other "ex drug abusers".
iii) Having experienced transformation on himself.
iv) Exhibiting a certain degree of compassion without pity.
v) Receiving trust more easily from other ex drug-abusers.

Many other aspects also give him an ideal position to exert therapeutic influence.

I do also agree that you need **not** have **Street experience** to be able to help others I can speak here from my own experience. But I must caution you that being 'straight' is not necessaily an advantage. I am inclined to believe that I will always be to a certain degree inferior to the former drug users on my Therapeutic Staffs, simply because there are certain areas where I cannot identify my own experience with that of the drug user. At the same time the absence of street experience is no hinderance to effective rehabilitation work.

Pusat Pertolongan has amongst its staffs, former drug users and 'straights'. Both work, side by side, and hand in hand, with no feeling of superiority or inferiority because of their post. Now let us come to the most essential aspect for the therapists in drug abusers' rehabilitation.

4) WHO BECOMES, OR WHO MAKES A GOOD THERAPIST?

There are so many factors involved in this question that I cannot go into full details. But I want to stress one point which I believe is important.

Only about 6 - 8 per cent of Graduates from a therapeutic programme are useful as clinical therapists, and only 2 - 4 per cent are very good. This explains why even our Organisation is having its staffing problems.

Of course, these figures can only be used when we apply the term "therapist" in the narrow sense, that is, a person with great expertise in dealing with personality problems and having the necessary professional knowledge too.

This classification does not mean that only a small percentage of former drug users are useful in a therapeutic set-up. On the contrary, the availability of these former users in assisting functions such as administration, workshops, maintenance etc. is of great importance. They can still make a big contribution towards the whole of rehabilitation and can even, to a certain extent, supplement the work of the "clinical therapist", if I may use such a term. Rehabilitation does not end with group sessions or counselling but is an ongoing 24-hour process lasting for months if not years

5) TRAINING OF THERAPISTS

The process of training can be considered as follows:

a) Selection ; finding suitable people
b) Preparation ; how they are taught
c) Expectation ; what they have to do
d) Qualification ; how they are judged

Let us now look at these stages one by one, as they are handled within Pusat Pertolongan.

a) Selection

The selection of potential therapists it usually done through observation of the resident's response, comprehension, intelligence, motivation to help, employment status and interest. The therapist usually has an experienced eye for detecting such potential and the trainee will respond by his behaviour and involvement.

b) Preparation

The trainee will then be placed in various group sessions and his other potentials like tolerance, emotional stability etc. will be tested and reinforced. While he goes through the various stages of therapy, he will be trained in the different aspects of administration dealing with the management of a Centre. If he still proves himself he will be called into the Management group of one Centre and given certain assignments and responsibilities. It is usually here that he learns and experiences the deeper and finer parts of therapy for himself and for others. He gradually becomes more active in group sessions and learns the finer aspects of therapeutic approaches. If a resident expresses an ambition to become a staff, he will be recommended for 'Probationary Resident Junior Staff' (P. R. J. S.). It is here that selection and preparation take a more concrete form.

The P. R. J. S. will be placed firmly in the training care of the therapist and will be given light job assignments designed mainly to test his responsibility and to put him in situations where he must understand other residents and handle them tactfully. For instance, he may supervise residents working in administration or manual work, he may handle certain confidential papers, or he may accompany residents outside the Centre.

This period takes approximately 4 - 6 months. If he has proven himself he will be promoted to a confirmed 'Resident Junior Staff' (R. J. S.) and will assume clearly defined duties where he needs an elementary knowledge of the different methods of therapy. He may run a small department of 4 - 6 people and be responsible for planning, discipline and recommending suitable therapy. He may counsel residents. He may even run certain therapeutic sessions under close supervision. He is given more trust and higher standard of behaviour is demanded. If after 4 - 6 months he has proven himself and shown willingness to learn, then he can be promoted to the post of "Resident Senior Staff" (R. S. S.). This phase is usually the last before graduation and will be a crucial period as he will have to decide finally whether to become an employee of the Centre or leave for outside employment after graduation. During this phase he is constantly guided by the therapist and at times prepares evaluations of residents. He is expected to recommend approaches. His main functions are geared to assisting the Officer-In-Charge of a Centre. He will carry out the instructions of his Officer for a 'family' of approximately 30 - 40 people. He may run certain therapeutic sessions under close supervision, and will aim to understand all therapy conducted in his centre in a concrete way.

The official training will only take place after graduation. The graduate who wishes to become a staff, either in the field of therapy or in other areas, will have to undergo further training. As Trainee Staff, they are employees in the sense that they are receiving an allowance of between $ 120/- and $ 250/- monthly.

c) Expectation

Trainee Staff still reside in the therapeutic environment, so as to have more opportunity to observe resident's behaviour. They have 4 - 6 hours seminars each week and group sessions which cover such topics as: human development and conditioning, modern therapy and theory, sensitivity and awareness, the effect of emotions upon mentality and behaviour, human relations, hygiene and nutrition etc. Most importantly, they continue a process of self-discovery aimed at personal growth and development.

Trainee Staff are often Acting Officers-in-Charge of a Centre. It is here that the Trainee Staff are expected to do private studies in human behavioural science. They are also brought into weekly case-study groups usually chaired by the Programme Administrator, Research Officer, President or Vice-President depending on the case and who has the best personal knowledge of it.

Trainee Staff are also further guided in the Philosophy of the Organisation and are rotated in the various sections of administration. A major aspect is their conducting of seminars for visiting groups; between January

and April 1978 we had 20 such seminars, and also occasional outside seminars. This gives a valuable opportunity to get into closer contact with different strata of society. They also talk to parents of residents and thus get insight into the background of drug abusers. Theme writing and case work are demanded frequently and discussed at training sessions.

d) Qualification

The Trainee Staff are only accepted as full Regular Staff when they have proven themselves to be mastering the concept of the therapeutic approaches, and are exhibiting complete responsibility and competence in their function. At this stage they will have gained the trust and confidence of the residents and Management of the Organisation. A precondition of becoming a full Regular Staff is to undergo two Attitudinal trainings (similar to those of the Outward Bound Schools) Level I and II, each of 5 days duration.

The period of training from the level of P. R. J. S. till full Regular Staff might be well 2 - 3 years.

This detailed description should give you a first insight into our requirements and expectations. We might not use formal educational standards and achievements as criteria, but we certainly expect more than just "Street Loafers" experience from aspiring Therapeutic Staff.

In this case it matters little whether the trainee has or has not been a drug-dependent; he still has to go through the same process and training.

Our therapeutic staff now comprises 4 "straights" and 6 former drug users, with an additional 8 trainee staff.

Our Resident Staff are as follows :-

P. R. J. S. - '8'

R. J. S. - '8'

R. S. S. - '2'

Conclusion

From personal, experience, I have come to recognise the value of former drug users as Therapeutic Staff. I also have to admit that there are dangers which must not be overlooked. I repeat again, an ex drug-dependent is NOT automatically a therapist. However the former drug user has undeniable potentials as a therapist and we must not hesitate to tap these potentials and make them useful and applicable in the fight against drug abuse.

Let me caution anyone who wishes to trust an 'Ex-addict'. Only Gold that can withstand the test of fire is proven; and only the former drug user who has been tested again and again over **years** - not days, weeks or months - can be entrusted with responsibility for other drug users.

The so-called poor experience with ex-users as therapists is not a failure of ex-addicts as such but is rather a failure of people to recognise the true issues involved.

I would like to appeal to all concerned, to

i) formulate clear and precise guidelines for the training of all therapeutic staff working with drug-dependents

ii) set out syllabuses with minimum requirements aimed at finally recognising them as ADDICTION AND BEHAVIOUR THERAPISTS-not only for drug abusers but also for alcoholics, juvenile delinquents, ex-prisoners and others who suffer from behavioural problems.

None of our present therapists have any identification or professional recognition. If we want to attract people in this field of work then we must be able to offer them at least recognition and a stable future.

Drug abuse and other behavioural problems are now beginning to be viewed in a new light, encompassing a whole range of human knowledge.

They need a NEW Approach.
Therefore we call for a New Profession.
Here we can and must learn to overcome bias and work towards effective and progressive solutions.

The "ADDICTION AND BEHAVIOUR THERAPIST" is a step in the right direction.

SUPPLEMENT I

RESEARCH CENTER. INC.
PUSAT PERTOLONGAN
MALAYSIA.

REFERENCE :
Working Papers - Rehabilitation
CLASS :
Working Papers on the "Addiction and Behaviour Therapist"
PRESENTED AT : Asian Regional Workshop on Drug Abuse, Treatment & Rehabilitation.

BY :
Yakob Bin Abdul Rahman

This paper has been prepared with the assistance of the Therapeutic Training Department of Pusat Pertolongan.

THE ADDICTION AND BEHAVIOUR THERAPIST

1. Purpose

In my first paper for the conference I discussed the role of Ex-Drug Dependents in a Rehabilitation Programme, and pointed the way to a completely new profession within our society, dealing with the human problem of drug abuse. I want to take a closer look at what this profession would actually do; indeed it is already active. We must be clear in our concept of therapy for drug abusers. We need to know what we are doing and how we are doing it. Let us discuss what makes the Addiction and Behaviour. Therapist's work special, and clarify the ideas which flow through this new profession.

We can start with an overall view of how Pusat Pertolongan is organised, for administration and for therapy.

2. Administration

Pusat Pertolongan is linked into the Welfare Services network in Malaysia coordinated by the Ministry of Welfare Services. It is run principally by its President and his Management Committee, which concerns itself mainly with therapy in all aspects, but which comes under the official Board of Visitors appointed by the Minister of Welfare Services. The Management Committee meets biweekly and implements therapy through the Officers in charge of the various centres, under the guidance of the Programme Administrator. The Officers in charge can utilise the services of technical and vocational staff, and also of the trainee staff. Ultimate responsibility for the whole organisation lies with the President's Office.

3. Rehabilitation Procedure

It will be helpful to tell you of the various stages which a resident of Pusat Pertolongan can go through. For the moment we can call it "Rehabilitation", but this is not a word I like to use, because it focuses

attention upon getting rid of drug abuse. However, drugs are not the real problem ; people are the problem. So later we can talk less about drugs, and more about developing PEOPLE.

The structure of our organisation is as follows. After admission (or readmission of an absconder) and detoxification, a resident will be introduced to the family in his centre, and thus joins an Intensive Therapeutic Community (T. C.). Here he learns basic therapeutic tools such as relating of true feelings, challenging of motives, and confrontation of negative attitudes. He is guided in self-discipline rather than being forced to conform to rigid rules. After sometime he can progress to a different style of T. C. with more mature residents, who can be trained in many ways and different fields according to their interest and capabilities. Such training is useful to him when he reaches the stage of re-entry to society and comes to the center only for aftercare. He may wish to stay on in the center as a trainee staff, or he may leave for work or for further studies. After a good period of consistency in his new drug-free lifestyle, he can be a graduate of Pusat Pertolongan's therapeutic programme. That briefly, is our structure.

4. Therapy and Training

Now with the framework in position, we can talk about our main concern, the therapy itself. What **are** we trying to do with the ex-drug abuser? What are we trying to give him, how will we go about meeting his needs and helping him to overcome his problems? Surely we need first of all to understand his present state; only then can we know how to proceed. We must first be clear in what his addiction really is. We must recognise the true condition of this person whom we intend to deal with.

As I said, drug abuse is primarily a human problem, and we must gear our solution towards people rather than towards drugs. We must gear our understanding towards people, rather than towards chemicals. The inability of the conventional methods to cope with the problem of drug abuse lies in its inability to see the problem in human terms instead of in pharmacological terms.

Addiction is not only a physical condition of the body, but is more a problem of the human mind. It is a sympton of a person's inner emotional problems, for which he has no solution, and for which his only outlet is drugs. We need to have a radical concept of addiction which allows us to understand our fellow beings as people.

5. What is Addiction?

I wish to put forward the notion that an addiction is a form of Escapism, an avoidance of harsh and painful reality. There are many forms of escapism in our society: drug addiction is only one of them. Others are alcoholism, gambling, womanising, gansterism and other forms of perverse social behaviour. A person who cannot face his own real problems seeks an outlet for his frustration, and the greater the frustration the worse is the outlet. Most of us are escapists to some small extent: we have things we would rather not talk about, things we discreetly avoid, people whom

we try to steer clear of, problems we would rather put off for a while instead of facing them right now. We relax and 'forget' about our worries, our frustrations, the conflicts which we don't want: some of us drink, some of us smoke, some go to the movies, and so on. We lose our frustration in pleasure and excitement. Our society accepts this in small doses; perhaps most of us tell ourselves that we are "more human" because we have these little weaknesses. However, when a person avoids his own realities and seeks outlets which become harmful to other people, then society objects. It is unacceptable to drink all your money away and deprive your family of food. It is unacceptable to be an addict, a parasite in society.

The underlying problem, though, lies in all of us; it is merely that some suffer more acutely than others. Escapism, the inability to face reality, is everywhere, not only in the addict. The remedy for addiction, as for any other form of escapism, , is to learn to face our reality, to learn to look life straight in the eye. We need to give the escapist a more **realistic** and **practical** attitude.

Therapy consists of helping a person to see what is really happening to others and to himself, confronting him with his reality, helping him to see things more clearly: helping him, ultimately, to be more honest.

Addiction and Behaviour Therapy, then, has this important concept behind it: the deviant is an Escapist and needs to get in touch with reality. Not the least part of his reality is emotional. He needs to accept and discover his own feelings, which may at times be very painful. Of course they are painful - why else would he avoid them?

6. Growth

This, then, is our present task. The therapy we intend to give involves the resolution of emotional conflicts in a person. We aim to take a person's present emotional and mental state and help him to develop, to progress, to resolve his contradictions , to grow into a future tree from the present seed. We will induce self-discovery, whereby a person continually finds out more and more about himself, sees more of his own feelings and attitudes, becomes more realistic in his view of himself and of his environment. Our ultimate goal for every person we deal with is unity and harmony within himself, integration of his whole personality. This process may be sometimes painful, sometimes happy, discouraging, joyful, or even funny. It is warm and human, fulfilling and exciting, joyful and magnificent. Getting in touch with your own reality is true freedom, because when you leave your addiction and escapism behind, you can face anything. That is growth.

7. The Therapist

Having got a clearer idea of what we're trying to do and why we're trying to do it, we can come to the main actor in my story, the Addiction and Behaviour Therapist himself. His job, simply and profoundly, is to keep being honest and realistic about others and about himself, and to help others to do likewise. It sounds easy, but it's not! And I don't think I need to tell you how hard it is, since most of you are working with escapists everyday.

In a T. C., our Addiction and Behaviour Therapist uses a group — — the community — — to achieve growth for everyone in that community. He creates situations in which people can interest with each other, and tell truth about each other. He must therefore understand not only individuals but also their relationships. Interaction between peers is sometimes a more powerful tool for growth than interaction with staff, because the element of fear of authority is absent. Ideally the therapist acts as a grand Master of Ceremonies in the T. C., creating interaction and better relationships. He is the conductor of a psychological orchestra.

However, the therapist must also be himself a part of the community. He must have real and caring relationships with the people under his care. He can be described as a "Participant Observer" : participant in that he is felt by the T. C. to be a part of their group, and observer in that he remains objective about what is happening within the group. He is a "professional friend", who gives emotional support to people who need it so they can grow. It is well recognised in social work today, particularly by our Ministry which has organised this conference and invited us to present this paper, that the human relationship between staff and client is highly important and crucial to the success of one's work. Personal attention for residents in a T. C. is vital for this reason. When a resident feels your concern for him, when he believes you are his friend, he trusts you; and then with his trust and your professional skill, transformation can take place in him. He can accept the reality which you show him.

Thus, we can see that the sole criteria for a therapeutic staff is his ability to see his own and other people's human reality, with its gamut of emotions, attitudes, fears, hopes and fantasies. His ability to leave behind his own escapism and to be more realistic and practical is all important. In this context, we can see that a record of drug abuse as such is immaterial for a therapist; all of us have our form of escapism, and if we can discard it we become more honest and start to grow. Of course, not everyone who grows can be a therapist. As I said in my first paper, there is a huge difference between someone who merely participates in the therapeutic process and someone who understands, stimulates, and guides therapy. There is a great difference between someone who is simply involved in the activities of a T. C. and someone who knows and directs what's really going on there.

It is in this sense of understanding people that out staff are professionals. They have a very clear aim in each of their respective T. C.'s, they know exactly what they are doing and how they are doing it. I would like to appeal again for their recognition as a profession in their own right, as Addiction and Behaviour Therapists.

The therapist is a seeker and a giver of truth. He looks always for reality. It is well said that he can only give what he already has; he must know many things about himself before he can really help another person to see reality. As Freud said, a therapist can only understand others to the extent to which he understands himself. So my message to you, if you would become an Addiction and Behaviour Therapist, is : Know Thyself!

SUPPLEMENT II

RESEARCH CENTRE INC.
PUSAT PERTOLONGAN,
PERAK, MALAYSIA.

MATERIAL : SURVEY ON THE ATTITUDES OF RESIDENTS TOWARDS LEARNING EXPERIENCES IN A THERAPEUTIC COMMUNITY

DATE : MAY 1978

Research Department
Pusat Pertolongan

INTRODUCTION

Learning Experiences (LEs) are a highly controversial aspect of many T. C. programmes. People who are not used to the T. C. concept often feel that an LE is a punishment, which will not help the person who gets it.

However it must be remembered that if you want to help a resident only by pleasing him, you are going to have problems. Change is a difficult process and it involves many difficult lessons, which are difficult preciously because few people like to face the hard truth about themselves.

An LE is, therefore, an experience which the T. C. staff create for a resident whereby he can accept himself as he really is and learn about himself. It is always handled with the utmost concern for the particular resident concerned, and is very flexible. It can include experiences such as (i) essays (ii) washing or cleaning (iii) removal of privileges (iv) wearing a cardboard placard with his negative attitudes written on it. (v) chipping off a lock of his hair; other LEs can also be implemented according to the feelings and attitudes of the particular resident concerned.

An LE is designed to help a resident to realise his own negative attitudes and to change them. This leads to greater self awareness and openes in a person. Of course, this is the intention of the T. C. staff, and may not necessarily be well understood by the residents. So this survey was conducted to find out the attitudes of the residents to LEs. Multiple choice questions were asked about LEs, and the answers were categorised according to the resident's length of stay in a T. C., since it was expected that those who stayed longer would have a better understanding of LEs.

QUESTIONS

1. How long have you been in the programme?
2. What is a learning experience to you?
3. Why is a learning experience given to a person?
4. Are learning experiences important in the programme?
5. Only when is a person given a learning experience?
6. If a person is given a learning experience and he takes it positively, what happens?
7. What happens to a person who takes it negatively?
8. Why do you think people sometimes refuse to accept LEs?
9. Do you think that a person is making a right or wrong decision by accepting an LE even though he feels unjustified in receiving it?
10. Do you think that LEs should be given according to the length of stay of the residents?
11. From your point of view, do you think that LEs should be implemented?
12. You were given an LE for a mistake but at that time you were feeling moody and worked up. How would you respond towards it?

13. The whole family got a learning experience for lack of involvement in Tools of the House but you feel that you have been doing your part. How would you respond towards it?
14. You have been given an LE for a fumble but you see the same fumble has been made by the person who gave it to you. How would you respond?
15. You have committed an offence and subjected to an LE. Who would you prefer it from ?
16. Why is it so?
17. Two people committed the same offence but got different LEs. What do you think of it?
18. You are aware that the Officer-in-Charge is giving a haircut to the Coordinator. Immediately after that, the Coordinator starts dealing with the family and gives a learning experience. How would you view this action ?

EVALUATION OF ANSWER SHEETS

The following deductions are made from the answers submitted by the residents. Please refer to tables when reading this.

Question 2

Residents with duration of stay of up to 7 months seems to have the idea that L.Es are for emotional growth. Although this is not completely wrong, they unconsciously feel that L.Es are a stress. The more senior residents believe that they stimulate inner awareness and openess.

Question 3

Results to this question show that residents with even a bit of seniority are aware that L.Es are given for negative attitudes shown. As can be seen from the tables, about half of the residents in the 1 to 3 month group regard L.Es as being given for their mistakes. This is quite expected because they still do not have the ability to differentiate between an attitude and a mistake.

Question 4

A majority of the residents agree that L.Es are important in the programme.

Question 5

For this question, although most of them felt that L.Es are given for repetition of attitudes/ mistakes, there are some who feel that they are given when other approaches fail. Both reasons are true. The residents seem to have an understanding of the reasons for L.Es.

Question 6

This question received a shared opinion. Seniors feel that they can grow from learning experiences. Most residents of the junior level take L.Es as a stop gap measure.

Question 7

This question received a shared opinion again. In fact, all three answers given to the question are possible response to the situation.

Question 8

The response to this question was quite similar to the one above. Here again the answers are all possibilities why some people refuse to accept L.Es.

Question 9

A majority of the residents are willing to accept L.Es in any situation. However, some juniors in the programme still show reluctance to accept L.Es, which in their opinion are unjustified.

Question 10

From the results of this question, it is very obvious that residents agree that L.Es are for everybody, no matter how senior or junior they are. They are also aware that L.Es should fit individuals and prevailing circumstances.

Question 11

It is of no doubt that residents believe that L.Es should be implemented in the programme. Nevertheless, some say that discreet should be practised when deciding when and when not to implement L.Es.

Question 12

Residents are willing to accept L.Es under any situation. It is natural for them not to feel it good at the moment.

Question 13

No matter how they feel, residents, both junior and senior will accept L.Es. A study of the figures in this table reveals about half of them will accept and teach by and the other half will follow since the rest are doing it.

Question 14

Even juniors can understand that they should learn to accept an L.E. for their attitude/mistake and use more diplomatic ways to clarify later on.

Question 15

A majority of residents have chosen to receive L.Es from any authority. Very few chose to particularly want it from the Programme Administrator because he represents high authority and is seldom in contact with the residents personally, unlike the Coordinator or Officer-in-Charge. This shows that interpersonal relationship plays an important part.

Question 16

They believe that it is the attitude that counts although some still prefer to receive it from someone they feel closer to.

Question 17

Residents feel that there should be flexibility in implementation of L.Es depending on the state of mind, seniority, circumstances under which the offence was committed, etc, very few felt that it was unfair.

Question 18

The bulk of the residents are in a difference of opinion. Some regard it as responsibility and about the equal number feel that it was done through feelings. It is really a matter of opinion of different individuals, of course, both are possibilities.

TOPICS COVERED BY THE SURVEY

Purpose of L.Es (Qu. 2, 3, 5, 6.)

Learning experiences are created to help a resident to build up inner awareness of himself so as to enable him to change his negative attitudes and behaviour. An L. E given to an individual will not only benefit him alone but also those around him. The most important thing to note is that L. E is not a punishment. It is aimed at enhancing the growth of residents.

Bad feelings about L.Es (Qu. 7, 8, 9, 12)

When an L. E. is given, the main motive behind it is to stimulate the inner awareness of a resident. But sometimes this is not necessarily understood by some residents, especially the more junior ones. They see it as a form of punishment for their mistakes. Seeing it this way, a resident will react negatively towards it by refusing to accept it altogether or accept it just for the sake of doing so. If this is the case they will not benefit from it and instead of growing and learning from it, he would feel bad about it, thus hindering his progress. There are also times when a resident is not in the proper state of mind when an L. E. is given to him. His clear thinking is affected by his emotions and he will feel unjustified about getting it. More senior residents usually see different after they have pulled themselves out of this emotional condition.

Value of L.Es (Qu. 4, 11)

A vast majority of the residents, even very junior ones, share the opinion that L.Es are important in the programme of a Therapeutic Community. It is evident that residents, especially those who have attained

some seniority, have benefitted from learning experiences. Improvement is usually shown after a resident has been subjected to an L. E. in whatever form tailored to correct his attitudes. As the name implies, an L.E will make a person learn.

Individual treatment (Qu. 10, 17)

Discreet need to be exercised when L.Es are implemented. Seniority or juniority, state of mind, prevailing circumstances, level of acceptance of a resident, etc have to be taken into consideration. There has to be flexibility and versatility in implementation. There must be creativity in L.Es and it is important to have follow up on the resident to check on how much he has benefitted from it. Even when a learning experience is given to a group of residents, it is important to make necessary modifications, inclusions, exclusions and additions if the need arises.

Group responsibility (Qu. 13)

L.Es can also create a sense of responsibility in the residents. Some times residents tend to forget that although their main aim in the programme is to help themselves, they should also be aware of their own surroundings and fellow residents. They are taught to practice Honesty, Trust and Responsible concern. Therefore in a group of residents or a family as we call it, it is the duty of each and everyone to be aware of one another and that they are progressing. An L.E will be implemented on the whole group if a significant number of them are displaying negative attitudes. As such, L.Es help to instil a sense of responsibility in residents. They are taught to be aware of their environment and fellow residents.

Fairness (Qu. 14, 18)

Only residents who have reached a high level of understanding of the programme (other than full regular staff) are entitled to give L.Es to residents. Usually this calibre of resident are Residents Staff i.e. residents who have reached a stage to implement the programme while still undergoing rehabilitation themselves. They are trusted to exercise fairness and to be objective when implementing L.Es. Sometimes residents see unfairness because they are emotionally affected and becomes irrational. However, it cannot be totally denied that unfairness could also be displayed at times. After all, the implementors are also humans with their shortcomings.

Who should take disciplinary action (Qu. 15, 16)

Residents prefer to accept L.Es from those whom they feel close to, usually the Coordinator or the Officer-in-Charge. Actually, the important thing is how it is being presented to the residents. Usually seniors are more objective in their views and are of the opinion that it is not the L.E or who is giving it but the reason for it being given.

SUPPLEMENT III

DATE: 5th May 1978.

REFERENCE :
(Letter reference no.) - PP/PFS/ 10 bhg. 3/169/78

CLASS :
Statistical Data about Pusat Pertolongan.

PRESENTED AT: Asian Regional Workshop on Drug Abuse, Treatment and Rehabilitation.

This paper has been prepared with the assistance of the Therapeutic Training Department of Pusat Pertolongan.

Research Department
Pusat Pertolongan

No. 2

ABSCONDINGS AND DISCHARGES

YEAR	ABSCONDED	DISCHARGED
1975	77	0
1976	147	0
1977	354	109
1978	132	61

3. BREAKDOWN OF LENGTH OF STAY IN THERAPEUTIC COMMUNITY BEFORE ABSCOND

The following figures are based on a random sample of abscondees from Pusat Pertolongan:-

Length of stay	*Less than 1 month*	*1 to 3 months*	*4 to 7 months*	*8 to 12 months*	*Over 1 year*	*Total(%)*
No. in 1975...(%)	14(19%)	18(23%)	31(40%)	11(14%)	33(4%)	77(100%)
No. in 1976...(%)	25(17%)	35(24%)	41(28%)	28(19%)	18(12%)	147(100%)
No. in 1977...(%)	19(12%)	44(28%)	72(46%)	18(12%)	3(2%)	156(100%)
No. in 1978...(%)	3(9%)	9(26%)	19(54%)	4(11%)	0(0%)	35(100%)

NOTE: The high percentage of absconds in the 4 to 7 month group results from people's false concept of rehabilitation.

COST OF REHABILITATION

Taking into account the total cost of running Pusat Pertolongan (i.e food, maintenance, staff salaries, transport, electricity, etc.) and the total number residents in Pusat Pertolongan, the cost of rehabilitation is $ 5.33 per resident per day.

This figure is based on expenditure and population during the current year.

NO : 5 CURRENT POPULATION

Listed hereunder is a breakdown of Pusat Pertolongan's residents in their respective phases:-

No. of Phase 1 residents	-	128
No. of Phase 2 residents	-	43
No. of Phase 3 residents	-	6
No. of Phase 4 residents	-	5
Total Population		182

Note: The above total also includes the resident staff. Listed below is also the present breakdown of Pusat Pertolongan's Staff:-

No. of Probationary Resident Junior Staff	-	8
No. of Resident Junior Staff	-	8
No. of Resident Senior Staff	-	2
No. of therapeutic training staff	-	8
No. of Regular Staff (Therapeutic)	-	15

NO : 6 CURRICULUM OF TRAINING THERAPEUTIC STAFF

Stated below is the complete list of subjects to be studied by the training therapeutic staff of Pusat Pertolongan :-

a. Psychology
- Basic emotions and their effect on mentality.
- Growth in a family.
- Development and Conditioning.
- Human behaviour.
- Modern therapy and theory.
- Sexuality.
- Sensitivity and Awareness exercises.
- Emotional problems and their effect on people's life.
- Body Language.
- Hypnosis and Dreams.
- Psychiatry. Psychological terms.
- Mental Disorders.

b. Social Science
- Basic social factors and their effects.
- Philosophy of human relations.
- History of drug abuse.
- The press and other media.
- Relationships between parents and children.
- The public's concept of drug abuse.
- The drug dependent in society.
- The laws about drug abuse and their enforcement.

c. Administration
- Techniques of management.
- Accountancy.
- Official regulations covering rehabilitation.
- Admission and Discharge ; After - Care.

d. The Therapeutic Community
- Therapeutic tools.
- Presentation in therapy.
- Research and statistics.
- Occupational therapy.
- Physical Hygiene and Nutrition.

First Aid.
Counselling.
The concept of a therapeutic programme.
The history of the therapeutic community (linked with religion)

e. General Topics
Bahasa Malaysia classes.
Methods of drug abuse.
The psychological effects of drug abuse.
The physiological effects of drug abuse.

f. Field Work Up to 6 months social work with a recognised organization.

TREATMENT EVALUATION RESEARCH IN MALAYSIA

By

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INTRODUCTION

The current status of knowledge on the relative outcome of different methods of treatment and rehabilitation is not sufficient for planners in a country like Malaysia to implement rapidly and with certainty an effective national programme for managing its drug dependence problems. For this reason it is of critical importance that evaluation research be included as an integral part of our early efforts to establish sound national programmes for the management of drug dependence problems. The issue is of equal importance to a number of countries in this part of Asia; as we are suddenly confronted with rapidly growing populations of urban heroin users. Given the many other pressing demands for resource allocation in our respective countries it is our mutual responsibility as advisors to our Government, to rapidly and systematically identify the most economic, practical and effective methods for treatment and rehabilitation of these young people.

In order to meet the need for a sound methodology to evaluate treatment and rehabilitation approaches, the National Drug Dependence Research Project at the Universiti Sains Malaysia has been, in collaboration with the World Health Organisation, testing instruments in a pilot study.

The objective of the research is to study the effectiveness of the three different types of treatment and rehabilitation services available to heroin users in this setting, that is outpatient withdrawal, Inpatient withdrawal and institutionalised social rehabilitation. The pilot nature of the study and the small number of cases involved, do not permit us to draw major conclusions on the effectiveness of these different approaches. Nevertheless the experience gained and the data collected have been instrumental in designing the larger and more systematic study which is now underway. We feel it might be useful to review the pilot study in this forum because it appears to illustrate many of the common issues that we all face in the proper design of studies, in selecting appropriate samples, and in locating our subjects in the follow-up phase.

METHODOLOGY

a) Description of treatment

Outpatient withdrawal patients are assigned to a centrally located general psychiatric outpatient clinic where they are instructed to gradually reduce their daily use of **heroin** or morphine over a 14 day period. To assist them in this process, they receive Chlorpromazine (LARGACTIL) 20 to 30 mg 3 times daily. Lorazepam (ATIVAN) 2 mg 3 times daily was also given. They are instructed to return to the clinic once weekly for counselling from the doctor and for collection of urine samples until they are found to be opiate free. When withdrawal is completed, patients are initially requested to report to the outpatient clinic fortnightly, then once every month.

The inpatient withdrawal procedure includes the medications described above, but the doses were varied according to the severity of withdrawal symptoms in an inpatient setting. No heroin or morphine was available so that an acute abstinence syndrome is precipitated upon admission. After the 4th day the medication is gradually reduced so that patients are generally drug-free by the 10th day and discharged soon after to the general outpatient psychiatric clinic for monthly, after care follow-up visits. During the hospital phase they received regular group counselling, some individual counselling and during the after care phase they received counselling from the outpatient clinic doctor.

If the subject is assigned to an Institutional Social Rehabilitation Programme following inpatient withdrawal as described above, he is isolated from the community for an additional six months. While in the 100 bed therapeutic Activity Centre, he receives according to his needs vocational training, religious courses, group and individual counselling, educational instructions, sports and other recreational activities. When he is discharged he is required by law to maintain monthly contact for a period of eighteen months with a counsellor designated by the Ministry of Welfare Services.

Sample selection and assignment

Heroin and Morphine dependent persons seeking treatment are seen at the General Psychiatric Clinic at Penang General Hospital in a centralised intake procedure. When they agree to participate in the study they are randomly assigned to one of the three treatments described. The study group is confined to males below the age of 40 years. Criteria for exclusion from the study include an established history of psychological disorder and/or presence of a health disorder or other conditions that might be adversely affected by the detoxification procedures.

Data collection

The Baseline Form developed in collaboration with WHO for treatment evaluation was administered at the time treatment began. Progress forms were administered one, six and twelve months after admission to treatment.

For the pilot study a sample of subjects were also selected for administration of progress forms, one, six and twelve months after being discharged from the social rehabilitation institution. In this way the issues related to follow-up of subjects admitted to this treatmet modality could be reviewed without waiting for them to complete the six month institutionalisation.

Physical examinations were administered as part of the treatment application procedure and urine specimens were collected at the time of treatment commencement and when each progress report was completed.

RESULTS

i) Description of subjects.

The purpose of randomly assigning subjects to the different treatments in a study of this type is that randomisation is likely to eliminate sample biases that are likely to influence the results of the treatments. For example if one of the treatment approaches were to be systematically assigned subjects with less education and higher rates of unemployment, with more arrests or imprisonments and previous treatment failures, these factors alone could account for poor results for this treatment approach.

TABLE 1 is presented to show how such treatment relevant factors are distributed among the study samples following randomisation. Ideally they would be distributed evenly among the different groups if a large number of subjects were randomly assigned. Indeed we observe even with the small numbers involved in the pilot study that the randomly assigned samples are roughly equivalent as to mean age, mean years of education and history of previous treatments for drug dependence. Note, however, the uneven distribution of history of being jailed for drug offences in the groups, although these differences are likely to disappear if larger numbers of subjects were involved. Observe also how the social rehabilitation non-randomly chosen sample differs from the three randomly assigned groups on two variables: they are older and have higher education levels. While these differences are not great, they suggest the value of randomisation and the need to include sufficient numbers of cases in such studies so that treatment groups will be roughly equivalent after randomisation.

FOLLOW UP RESULTS

All subjects were followed up one, six and twelve months after assignment to treatment. Note from TABLE 2 that all but one of the 53 subjects was located at the one month follow-up, but that 19 (37%) could not be located at the end of the sixth month and a further 4 (7.4%) after twelve months. Note also the missing subjects are rather evenly distributed among the treatment groups. Interviewers were instructed to make three visits to the home of each subject before abandoning the search and to report on what information was available.

The data are interesting in suggesting that a rather high percentage of relapses occur among outpatient (42%) and inpatient withdrawal (58%) groups by the first month post admission.

TABLE 1

Distribution of treatment Groups by Factors Relevant to Treatment Outcome.

	Out-patient withdrawal N — 17	In-patient withdrawal N — 12	Social Rehab N — 10	Soc Rehab Non Random N — 11	Total N — 52
Males (%)	100	100	100	100	100
Mean Age (yrs.)	25.1	24.8	24.8	27.2	25.4
Mean Education (yrs.)	7.8	7.9	8.9	9.3	8.4
Mean Number Previous treatments	1.6	1.1	1.7	1.6	1.5
Mean times Jailed for Drug offence	0.6	0.1	0.4	0.2	0.3

TABLE 2

Follow-up after One, Six and Twelve months

Treatment GROUP	Drug Use Status at Follow-up	TIME of FOLLOW-UP INTERVIEW		
		1 month n (%)	6 month n (%)	12 month n (%)
Out Patient	Abstinent	10 (53)	7 (37)	7 (37)
n - 19	Relapse	8 (42)	4 (21)	2 (10)
	missing	1 (5)	8 (42)	10 (53)
Inpatient	Abstinent	5 (42)	4 (33)	4 (33)
n - 12	Relapse	7 (58)	7 (58)	2 (17)
	missing	—	1 (8)	6 (50)
Soc Rehab Random	Abstinent	7 (70)	7 (70)	6 (60)
n - 10	Relapse	3 (30)	0	1 (10)
	missing		3 (30)	3 (30)
Soc Rehab	Abstinent	10 (91)	7 (64)	5 (45)
Non-random n - 11	Relapse	1 (9)	0 -	1 (9)
	missing	—	4 (36)	5 (45)

This tendency to relapse continues in both groups with 67% of inpatients and 63% of out-patients either relapsed or disappeared by the twelfth month.

If the outpatients were to continue to do as well or slightly better than inpatients in the larger study, this would have significant implications for reducing the cost of withdrawal services. It must be stated, however, that trends reported here do not correspond to the findings reported by investigators in other settings.

The follow-up data for the social rehabilitation - randomised group are interesting in that 30% admitted drug use at the one month follow-up; this could possibly suggest that illicit drugs were being smuggled into the centre. We observe that 30% had absconded from the institution

and were not available for the six month follow-up. These data reinforce the importance of comparing treatment outcome on subjects randomised from the same base population. It suggests how, for example, the social rehabilitation - non random group was already a biased sample because they did not include subjects who had absconded during the first six months of institutionalised treatment.

The social rehabilitation randomised group would be expected because many were still institutionalised to show a high percentage of abstinent subjects at the end of six months. However, this trend continues at the twelfth month and if it continued in the larger study, it might suggest that prolonged removal from the community and additional expenditure of resources could result in higher abstinence rates. In this case planners would have to weigh the extent of the differences in relapse rates against the additional expense and other negative effects of prolonged institutionalisation.

PROBLEMS EXPERIENCED IN THE AFTER-CARE PHASE

Data were collected on a number of other variables relevant to treatment outcome, but time and space do not permit them all to be reported here. Of particular interest were the types of problems confronted by subjects during the after care phase of treatment.

We note in Table 3 that 48% of the subjects reported at least one type of problem at the six month follow-up and in Table 4 that 80% of the problems were reported by only one third of the interviewed subjects. We further note in Table 5 that the subjects who had relapsed to drug use reported four times the number of problems (2.1 vs 0.5). One cannot judge from the data available whether the problems were the cause or the effect of their relapse to drug use and this question would have to be investigated further in the larger study.

By examining further the relationship of relapse to type of problem reported, one can begin to think more systematically about the structuring of after-care services required by the drug users under study. For example, virtually all of the relapse cases (Table 5) reported health problems, approximately half had family problems, with employment and economic problems next in order of importance. Psychological and criminality (courts, arrests etc.) problems appeared to be negligible; the reason for this, of course, might be that the subjects with serious difficulties with the law were among those who could not be located in the follow-up study as they may have moved to other communities to escape arrest.

If further research supports these trends, we will need to structure after care services that are multidisciplinary or multiagency in nature that either provide or refer patients for health care, family counselling, employment and economic assistance. These services might be more efficiently directed at a minority of after care subjects who are experiencing most of the difficulties. Those subjects who are abstinent may have fewer problems to discuss with after care staff and may need to be seen only periodically, to monitor their progress or to offer more intensive assistance when problems arise.

DISCUSSION

After presenting data from this study and after indulging in a number of speculations as to their implications, the authors wish to reaffirm the pilot nature of this work and that a more systematic study with larger numbers of subjects is now being implemented. Because of the small sample size in the pilot study just described and because of certain biases in the samples studied, it is not possible to draw conclusions on the effectiveness of the several treatment approaches under study. The experience gained and the preliminary findings have been invaluable, however, in improving the design of the larger study and in demonstrating the applicability of the WHO instruments in a country like Malaysia.

Despite the pilot nature of this study, it may be useful in illustrating some of the issues that confront all of us in conducting treatment evaluation studies: issues of sample selection, of the various factors that may relate to the relapse of patients in after care programmes, and the issues of how evaluation data may suggest the restructuring of services to improve overall programme effectiveness.

A major issue identified in the pilot study was our inability to locate and interview a significant proportion of the subjects. Interviewers were required to visit the residence of all subjects at least three times before giving up the search. If the subject was known to be working, his place of employment was to be visited if he was not at home. Interviews with the families of the 19 subjects missing from the six month follow-up suggests that two were in jail and six have left this region of Malaysia to find work elsewhere and to get away from their drug using associations. But the majority (n = 11) of missing subjects simply disappeared after persistent and intensive family conflicts over their drug use. The information is useful because it suggests the majority of subjects missed in the follow-up have relapsed. If further research supports our impression, it also suggests the need to involve the family in the treatment process. Could a significant proportion of these missing subjects have been helped to withdraw again if their families had closer contact with follow-up staff? We will need to clarify further the nature of these family conflicts and how the intensive rejection of drug abuse by the families of our subjects can be mobilized to help them stay off drugs.

TABLE 3

Subjects reporting one or more problems (N = 33)

No. of Problem Areas at 6 months follow-up	Percentage of subjects
0	52
1	18
2	15
3	12
4	3
5	3

TABLE 4

Subjects accounting for the majority of reported problems (N=33)

Number of subjects (n — 33)	Percentage of total problems reported
15	90
11	80
6	70

TABLE 5

Relationship of Relapse to Reporting of Problems (N = 33)

Problems at six month follow up	Abstinent (22)	Relapse (11)
Health Problem	1	10
Family Problem	2	5
Employment "	4	3
Economic "	2	3
Psychological "	1	1
Criminality	0	0
Total problems	10	23

Another limitation in the study seems to be inherent to the types of programmes being evaluated. The approaches being compared in this study are more than merely different methods of treatment. They take place in different institutional structures; admission to the social rehabilitation programme places the subject in a different legal framework in which a three to six month institutional rehabilitation and monthly visits to after-care programmes are compulsory. The duration of the intensive treatment phase is different in the three approaches. Lasting only two weeks for the inpatient withdrawal group from two to six weeks for the outpatient withdrawal group and six to seven months for the social rehabilitation group, If differences are found in the outcomes of these three approaches they can only be attributed to global programme differences - even though they may in fact be due to only 1 or 2 elements of these very complex programmes.

For the present, however, it is not necessary to study the specific contribution played by each element in a programme. We are still at an early stage in our work, which is merely to determine the global rates of success and failure in the programmes now being offered to heroin users in Malaysia.

A related limitation in the study design is the absence of a control group, that is a group that receives only placebo treatment or no treatment at all. While this would add to the scientific merit of the study, the investigators felt that it would not be ethical to withold any of the potential benefits of the treatments included in the study from heroin users who are seriously dependent on the drug and who each day face, the threat of arrest and other hazards associated with their drug dependence.

It is the authors view that many of the limitations frankly acknowledged in the study are acceptable and in most cases not avoidable. Treatment evaluation research in the countries of this region cannot be carried out in laboratory settings isolated from the realities of work in the community. The research cannot be theoretical in its impact; it must assess practical programmes that are being offered now or which can be offered in the relatively near future. In the end our research will not be judged so much by its academic or scientific elegance, rather it will be judged by its relevance to the fundamental and practical issues confronting national programme planners in our respective countries.

Acknowledgement

The authors express their gratitude to

Mr. Lee Boon Aun, Research Associate Drug Dependence Research project, for analysis of the data presented in the paper;

Dr. Pierre Renault, National Institute on Drug Abuse, U. S. A. who served as a WHO consultant on the study design.

Dr. Raja Ahmad Noordin, Director - General of Health and Encik Adnan bin Haji Abdullah, Director - General of Welfare services for providing the necessary facilities;

and to the numerous supporting staff at the University and Treatment Centres who made the study possible.

THERAPEUTIC COMMUNITIES—A BRIEF REVIEW

By

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The term therapeutic community, as it is used in drug treatment, does not mean the unique form of social organization created by Maxwell Jones in England to treat the mentally ill. Comparison of some basic concepts of Dr. Jones with some basic concepts of Charles Diderich, the creator of the therapeutic community method with drug dependent persons, should illustrate how diametrically opposed the uses of the term therapeutic community can be. First, Jones says that as much power as possible must be shared in the social setting which he calls a therapeutic community and which he created to assist the recovery of the mentally ill. Diderich, on the other hand, says that power must be won by an addict in what he calls a therapeutic community. The addict, in Diderich's view, would only misuse power and sharing power would be inappropriate until such time as the addict has demonstrated acceptance of the power structure and the principles of the therapeutic community.

The two definitions of therapeutic community are based on two different views of the psychology of human beings. For Diderich the notion of an unconcious was unacceptable particularly with the corollary that people often had feelings and thoughts they were not aware of. Diderich rejected any notion of an unconscious. He felt that addicts knew what they were feeling and thinking and had absolute responsibility for reporting their feelings and thoughts.

Jones notion of a therapeutic community dynamic for the mentally ill carried with it no rejection of classical views of the unconscious. Diderich felt that the addict could not act responsibly and had to be monitored closely - so closely that all communication with the family and friends had to be very carefully screened if it was permitted at all. This view, of course, contrasts sharply with the view of Maxwell Jones who felt that the mentally ill person could act much more responsibly if given the opportunity to do so. Jones critique of the social dynamics of the treatment structure created for the mentally ill were based on his perception that the mentally ill were much more capable of exercising responsibility than current theories on mental illness conceived them to be. Jones felt that recovery depended upon their exercise of social responsibility.

Comparison of these two viewpoints could be extended but the purpose here is to arrive at some definition of the term therapeutic community for drug abusers while pointing out that in ordinary mental health circles it has quite a different meaning.

The essence of the definition of Therapeutic Community for drug abusers is the concept of a graded resocialization process for addicts in which they win status and power by demonstrating compliance with the power structure and principles of the programme. The resocialization goal includes a basic view of the addict as an untrustworthy person without a conscience.

Therapeutic Community, as it is used in drug abuse treatment, also implies an extended commitment to the resocialization process; committment which usually would be measured in terms of months if not years. This commitment implies residential living with a more or less complete severance of family, social and vocational ties. It also implies a staff drawn from the ranks of drug abusers.

Classically access to therapeutic communities was difficult. In the original Synanon programme, for example, addicts were often sent away from their initial intake interview to return in days or weeks if they were really sincere about wanting to change their life style. And in the classical Therapeutic Community withdrawal from current drugs of abuse was without chemical support. This was the "cold turkey" approach.

In the Synanon version of the therapeutic community the addict was seen as the victim of pathologic social forces which had not permitted maturation to take place. The goal of the therapeutic community programme therefore was the maturation of the addict by immersing him or her in the set of activities, encounter groups, educational seminars, etc. which constituted the programme. The addict would then be able to be trusted, would be able to exercise control over drug taking and would be capable of social living.

Inside of Synanon there was a split over the issue of the ultimate goal of treatment. All agreed that the addict could be resocialized to the point where they could be contributing members of the Synanon community. But could they leave Synanon and function satisfactorily in the "straight" society? - the society which had failed them so miserably in the first place. Diderich appears to have felt that the answer to this question was that the addict could not afford to risk exposure to the noxious forces that had led him to a life of addiction. But many Synanon graduates have felt differently and have attempted to live in the straight world. The question of ultimate goals is still not resolved. Those who do leave Therapeutic communities in which they have been clients frequently work in drug treatment programmes so in a sense they have not left the extended family of drug abuse treatment agencies.

The matter is important for this group to consider. If you elect, as I think you should, to incorporate therapeutic community concepts and treatment units into your national demand reduction efforts you should try to be specific about your ultimate goal. My notion is that you should elect the therapeutic community model which attempts to return addicts to "straight" society. There is no inherent reason why this cannot work. Our experience in Illinois, where we created Gateway Houses with this explicit premise in mind, is that it can work for many.

One could theorize that a therapeutic community is effective because it does two things for the addict. One it offers sustained contact with other human beings which are free of drug taking or participation in criminal activities. This has the effect of reducing the psychological isolation inherent in the drug abusers life style. Two, the therapeutic community becomes "in loco parentis" and also becomes in a sense an extended family. This may account for the fact that more than half of graduates of Therapeutic Communities or in other drug treatment programmes after they graduate. No one in the West has experimented with the creation of different paths for the graduates of Therapeutic Communities in a formal, systematic programmed way. I have just said that our clinical experience in Illinois with Gateway Houses was that it could work but we could not get the resources to make a formal programme and to evaluate it. I know of no reason why such alternate post graduate routes should not be successful.

In the West we have not thought sufficiently of the goal of rehabilitation; or as some prefer to call it, habilitation; those preferring this latter term quite correctly point out that many addicts have never had a stable period of psycho-social functioning to which they may return and therefore the term habilitation or primary socialization is the only logical one.

We have not regarded the building of confidence in the addict in his or her ability to compete under ordinary social and vocational conditions with the importance that these issues deserve. Frequently addicts have quite low self esteem and an expression of this low self esteem and of their fear of competing is seen in their poor selection of friends and jobs, which serve only to reinforce their low self esteem. They may have received sufficient support to give the appearance of ability to function in normal society but in fact they are only able to function satisfactorily in the somewhat artificial world of the Therapeutic Community. They require additional formal programmatic support to take the next big step toward successful competition in the community at large.

In thinking about Therapeutic Communities from a policy perspective one should keep the following points in mind:

1. Therapeutic Communities are effective with a variety of drug problems. Heroin addicts or other kinds of opiate addicts or "poly drug" users can all be treated in therapeutic communities. This fact contrasts sharply with the limited applicability of narcotic substitution programmes such as Methadone Maintenance or maintenance with Methadyl acetate the long acting methadone. Given the fact that the social problems of drug use, abuse and dependence change so rapidly - in the US the treatment system we built 10 years ago does not fit well with the drug problems we now face - the versatility and usefulness of therapeutic communities as core components in a demand reduction strategy should not be underestimated.

2. They produce the best results when they are successful; in the West, at least, graduates of Therapeutic Communities are the most impressive in terms of their productivity and genuine change in life style.

3. But therapeutic communities have a high drop out rate. Diderich mentioned a figure of nine out of ten applicants not being admitted. This figure is not a bad rule of thumb when one is reviewing the question of applicability of therapeutic community programmes. Therapeutic communities will not be applicable to most addicts - at least under the social conditions of Western countries.

   The issue of forced versus voluntary treatment is relevant here. Most of the addicts in treatment in the United States are under some form of pressure to get into treatment. Most frequently this is formal legal pressure but in other instances the pressures are informal but are nonetheless real. The truly voluntary patient in treatment either in Methadone maintenance or in a Therapeutic community is unusual. (So I would answer the question can addicts be helped in coerced treatment with an unqualified yes.) The point here is that therapeutic communities have low acceptability for addicts. This is particularly true for the addict who has a legal job and a healthy marital or family situation. Such people are not likely to meet the demands of therapeutic communities to sever such ties nor should they. The basic problem with therapeutic communities is that they have low acceptability for many addicts and therefore have limited applicability in the demand reduction effort.

4. I will only mention in passing my belief that therapeutic communities can, at best, be only a component of a system of treatment approaches. We can expand upon the multi-modality concept during the discussion period if you like.

5. In the west therapeutic communities are more expensive than narcotic substitution and out-patient withdrawal programmes. The factor is about two to three to one. It costs about 2 thousand dollars per year to treat an addict in out patient Methadone and about five thousand to six thousand dollars per year to treat an addict in a therapeutic community. Our national evaluation data, gathered by Dr. Sells and published recently in five volumes, suggests that therapeutic communities are about as successful as Methadone maintenance programme in terms of desirable outcomes.

   Dr. Sells finds that these two approaches are more successful than detoxification. I hope you do not fall into the error of comparing therapeutic communities with Methadone maintenance and concluding that since Methadone maintenance is much cheaper and is equally successful then it is the treatment of choice. Remember that therapeutic communities and narcotic substitution efforts recruit from different pools of addicts and that addicts are not

homogenous. The comparison should lead one to appreciate the need for a coordinated demand reduction effort which includes all the known treatment methods under the banner "Different strokes for different folks".

6. In the United States, the therapeutic communities benefit about one quarter to one third of their clients. This statement is based on our national data and from data gathered by us in the Illinois Drug Abuse Programme. It also appears that there is a positive linear relationship between time in treatment and success. Those in treatment for nine months are better off than those in treatment for eight months and so on.

7. The therapeutic community is much more flexible than most people believe it to be. The early proponents of therapeutic communities were evangelical and relatively rigid about "their way". Drs. Rosenthal and Densen-Gerber in New York with Phoenix House and Odeysey House respectively demonstrated - as we also have in Illinois - that the basic utilization of a social dynamic for winning of status and a share of power in the community can be used effectively to construct treatment efforts for youth and for other special populations such as unwed mothers. Almost every original tenet of Diderich has been altered without compromising the underlying vitality of the therapeutic community concept. In Illinois, for example, we decided to give addicts chemical support during withdrawal while they were in therapeutic communities. This required training of staff - a training which was difficult because of the evangelism of those recruited from Synanon to help us build our therapeutic communities. But eventually, we, the administration, won out when staff saw that clients were able to adjust faster to the programme and had less suffering because we were withdrawing them gradually on Methadone. They came to accept our notion that chemical status, while not irrelevant, was not the sole or even the most important consideration. What the addict was doing or was not doing about changing his or her life style was. We had patients in the therapeutic communities we built - Tinley Park, Safari House, Crossroads, PFlash Tyre who were withdrawn from "poly drugs" as well as from opiates while they were participating fully and without friction in the dynamic of the therapeutic community. We also had patients on narcotics blocking agents who were in "living in working out" phases of the programme.

   Further testimony to the flexibility of therapeutic communities was generated by our experience in creating therapeutic communities whose purpose was to supplement our out patient treatment efforts - these units were short term facilities - a few weeks to a few months - and were geared to respond to a crisis in the life of the out patient. Frequently an out patient would be unable to resist the social pressures to engage in crime and/or drug taking or would be involved in family crisis so severe as to be intolerable

   or patients successfully abstaining from narcotics would be using alcohol or other non-narcotic drugs. In these instances we would work with the patient to gain acceptance of the idea of a temporary retreat - to get off drugs of abuse - to escape from an intolerable social or family situation - in order to become reoriented and strengthened - in short for crisis resolution. We found that Modified Therapeutic communities - and some of you in this audience have visited them could serve this purpose well.

8. I will only touch briefly on the complicated and important issue of who should staff therapeutic communities. Ideally the staff should be a mixture of professional and exaddicts. In the United States we have made the error of hiring exaddicts then attempting to train them. In many instances, the training has not taken place. With the advent of National Health Insurance the issues of licensing and accreditation are threatening the status of exaddicts with the real danger that the drug treatment effort will lose their creative contributions. My advice at this point would be to train them before hiring them and to provide some form of accreditation and licensing to protect them.

The flexibility of the basic Therapeutic community concept is nowhere better illustrated than in the instance of modifications of the classical scheme to create treatment structures for youth. In Illinois we made successfully the following changes:

1. We brought families into the dynamic of the house. We continue to limit initial communication but wherever possible we attempted to deal therapeutically with the family so often clearly responsible for the young person's involvement with drugs.

2. We softened the penalties for deviance from house rules by bringing the power dimension much closer to Maxwell Jones then to Charles Diderich. Patients routinely make decisions in re passes, loss of privileges etc. etc.

3. We used chemicals wherever necessary and have successfully trained staff to accept this.

4. We have made admission a low demand rather than a high demand experience. We made it OK for admission interviewers to be 'soft', and supportive. We feel that this has made far better retention rates in our Therapeutic communities for young people.

5. We have used a young staff with many more female staff members than were employed in classical Therapeutic Communities. This was a concious attempt to provide role models for young patients and to respond to the fact that in the United States females are now as frequently represented in drug abuse populations as males.

6. We explicitly created the expectation of complete reintegration with main stream society. Going to high school classes, fully accredited by local school systems is an integral part of our Therapeutic Community programmes for young people.

7. We incorporated psychological - psychiatric concepts where applicable. The basic group mode remains confrontational but troubled young people - and there are many of them-may receive psychiatric therapy including psycho-active drugs.

We also found that we could use Therapeutic Communities in lieu of much more expensive hospital beds for detoxification of many addicts. Our findings in this regard are in close parallel with the findings of the Toronto researchers to the effect that most alcoholics can be detoxified in non medical settings. We found that therapeutic communities costing one tenth as much as hospital beds could be used to detoxify most drug dependent persons - regardless of the drug involved. Presently, for example, we carry out all opiate detoxification and almost all dependence on Central Nervous system depressants in our modified Therapeutic Community settings.

I hope the foregoing gives some feeling for the real flexibility of the Therapeutic Community concept. One of the issues confronting the Therapeutic Community Movement now is that of its focus. Should it concerned exclusively with drug abusers? I have felt for a number of years that it should not, that this concept is widely applicable to the needs of societies in change wherever the change acts to humanize and depersonalize so many people and in particular the young. Therapeutic Communities have the potential for contributing along a broad front to the needs of the alienated and to those who feel powerless in modern societies and who as a consequence fall into deviance with or without the narcotics of drugs as a concommitant.

In any discussion of treatment of drug abusers I should mention the importance of keeping in mind the basic difference between the treatment perspective and the public health perspective. No disease - including drug abuse - is likely to be eradicated by treatment. This is true historically and there is no national experience anywhere on the world to change this truth. Thus, it is important to maintain credibility with funding bodies i.e. the politician and the people that we do not sell treatment as a public health solution to the drug abuse problem. We should sell drug abuse treatment as part of coordinated strategy aimed at ameliorating the problem not at eradicating it. We are much better at treating drug abusers in the United States than we were 20 years ago but we have not made any inroads in our public health problem of drug abuse which is, if anything, worse than it was 20 years ago. The same remarks incidentally apply to our substantial public health problem of hypertension. We are much better at treating it once it occurs than ever before but we dont know how to stop it from occurring.

So in conclusion let me state that I see Therapeutic Communities as a response to the dehumanization inherent in urban living in societies being changed by technology. Therapeutic Communities have literally an enormous untapped potential and I hope that you will consider our efforts in the west as preliminary explorations of the potential of these concepts rather than as fixed responses whose form and purposes must be preserved.

The one stable thing about drug problems is their instability. As a consequence we need constantly to change demand reduction strategies. I hope that you in the East will be more successful at this than we in the West have been.

Discussions

MR. ADNAN BIN HAJI ABDULLAH, Director-General of Social Welfare presented a paper on "Developing a National Rehabilitation Programme for Drug Dependents in Malaysia" Questions raised were mainly on supplementary details of the presentation.

(1) The time-lag between a person asking for treatment and his/her actual admission in a detoxification centre vary between 2 weeks and 6 months. However, it is guaranteed that he /she can get admission in a rehabilitation centre immediately upon discharge from the detoxification centre. This is because the Social Welfare Office and Medical Department work together in arranging for admission into a rehabilitation centre.

(2) The Cabinet Committee composed by 7 ministers under the chairmanship of the Deputy Prime Minister and the Action Unit under the Chairmanship of the Deputy Prime Minister and headed by the Deputy Minister of Home Affairs coordinate the actions of the various governmental and non-governmental bodies in the field of drug abuse in Malaysia.

(3) 60% of the social workers in the rehabilitation centres are professionally qualified, their average age being 35 years. Their work comprises the preparation of reports to the court, supervision and after care for drug dependents. While under supervision or after-care the ex-drug dependent can have his urine tested at any time and he can be required to attend Day Centres or out-patient clinics.

(4) Detoxification is carried out in 7 hospitals at present. In future when the comprehensive rehabilitation centres are ready detoxification will be carried out in these centres.

(5) The average caseload size of one welfare officer at present time is 40.

(6) The main task of voluntary supervisors who are members of rehabilitation committees is to assist the social worker in rehabilitation.

(7) The distinctions between suspected addicts, addicted offenders and volunteers are explained in extent in the paper. It was, however, pointed out that the suspected addict would have 3 alternatives to follow :

(i) To go free if he is drug free

(ii) To be referred to a rehabilitation centre

(iii) To be placed on probation

To be a drug dependent is not an offence in Malaysia. This provision of the law is to bring suspected drug dependents (who may not be capable of making a decision to seek treatment) into the rehabilitation programme.

(8) Counselling services in the rehabilitation centres include all types of techniques including value clarification techniques.

MR. YIP PENG LOW's presentation was on "Institutional Rehabilitation of Drug Dependents in Malaysia". The following questions by the participants were raised :

(1) *What do you do about deviant behaviour?*

If any resident manifests deviant behaviour of a psychological nature he will be referred to the psychiatric for treatment. If he wilfully breaks the centre rules and regulations, he will be dealt with in accordance with the Management Rules of the Centre. However, if he is found in possession of drugs or commits an offence defined in the Dangerous Drugs Ordinance such as escape, he will be referred to the police for appropriate action.

(2) *How do you deal with sexual problems?*

In the course of my experience I have only come across a resident who masturbated frequently. He was referred to the Medical Officer for advice. No other serious sexual problems were encountered may be because residents are given home leave after 3 months stay in the centre. Again wives and girl friends are encouraged to visit the residents; thus it appears that such measures help to minimise sexual problems within the centre.

(3) *How do you screen residents? (for homosexuality, etc.)*

Such screening is normally done by the In-take Officer of the Social Welfare Department when reports on the resident's social background are being prepared. If he is found to be unsuitable for institutional treatment, he can be put on probation by the Court instead.

(4) *Are conjugal visits permitted ?*

There are no such facilities at present in any of the centres.

(5) *What are the maintenance costs of the centres ?*

The cost of maintaining a resident in the institution is roughly $ 250.00 per month; but I am sorry I do not have figures on out-patient centres. Day Centres are new developments sponsored by a voluntary organisation - the National Association for the Prevention of Drug Abuse - PEMADAM. But in my opinion, it is definitely more expensive to operate a Residential Centre than a Day Centre.

(6) *Sleep - disturbance*

I have not personnally encountered serious sleep problems, but occasionally a case or two does arise. The majority of new arrivals can get to sleep because of their having gone through very rigorous exercises and activities. Again, they have to get up at about 5.30 in the morning.

(7) *Size of the centres*

3 Drug Rehabilitation Centres (DRC) have been set up by the Ministry of Welfare Services :

(i) DRC, Bukit Mertajam in the State of Penang - 100 residents

(ii) DRC, Kuala Kubu Baru in the State of Selangor - 180 residents

(iii) DRC, Johor Bahru in the State of Johor - 100 residents

(8) *What simple therapeutic techniques are being used?*

(i) Detoxification for withdrawal symptoms

(ii) Exercises and callisthenics to restore health

(iii) Army drills to enhance discipline

(iv) Religious instruction to strengthen their beliefs

(v) Vocational therapy to keep the residents busy; development skills, use of existing skills to make work more meaningful, and to help develop good working habits

(vi) Individual Counselling

(vii) Group counselling - airing of personal problems,
- confronting other residents under proper supervision
- discussing topics of mutual interest
- psycho-drama (role-play)

(9) *Do counselling services include or at least consider the use of value clarification techniques?*

Counselling is aimed at the self-realisation of the counsellee through the reconstructing of new personal values to enable him to function more effectively. Attitudinal change is the target whereby the individual is helped to see that the personal resistance increases one's level of stress tolerance (i.e. to have faith in oneself so as to cope with problems).

DR. NAVARATNAM's paper on "Treatment Evaluation Research in Malaysia" was briefly discussed as the author pointed out that this study is at present in its testing phase. Hence, no conclusive date is yet available. It seems,

however, that the methodology employed could be used in other countries in the South East Asian Region, and could, indeed, be used for obtaining internationally comparable data.

Numerous questions were asked following ENCIK YAKOB BIN ABDUL RAHMAN's paper on "Ex Drug dependents as Therapeutic Staff in a Rehabilitation Programme". They were as follows:

(1) *Concerning the training of the Therapeutic Staff, who does it and how many?*

The total number of trainees undergoing training is 8 staff plus 12 Senior Residents = 20.
The training is carried out by the Managing Staff with the assistance of a psychologist and other medical personnel.

(2) *What is the procedure to promote a person from one phase to another?*

Behaviour and responsibility in consideration with length of stay.

(3) *Is there any urine test carried out on all staff members and clients ?*

No, we do not make any urine tests.

(4) *What is the minimum qualification requirement for your ex-addict therapist?*

Lower Cambridge Examination.

(5) *There seems to be a lack of appropriate screening on admission. Might this not be of serious damage to the patient?*

The Social Welfare Department will take over the screening in the near future.

(6) *Is it realized that psychological characteristics of the clients and of the staff have a great significance?*

We are aware of this fact and take it into account in our daily activities.

(7) *The learning experiences have a frightening effect on the clients. How do you regard this question?*

We take some of this negative effects away by explaining to them the procedure and keep a close observation of responses on the subject.

The questions raised in connection with PROFESSOR E. SENAY's paper on "Therapeutic Communities", were as follows:

(1) *For what other behavioural disorders could you use the Therapeutic Community?*

One could use a T. C. to deal with sociopathic behaviour disorders, alcoholism or other so called "Volitional Disorders". The T. C. concept could also be used as a structure for halfway houses or for young people who are wards of the state i.e. have no parents.

(2) *Would you recommend mixing patients of different sexes ?*

Yes, nothing in my experience or in theory presents any real obstacle to treating mixed groups with respect to diagnosis on sex.

(3) *Would you combine alcoholics and drug addicts in T.Cs?*

Yes, I would combine alcoholics and drug addicts, the staff must be properly trained however.

(4) *Costs of T. C. and Methadone maintenance ?*

In US dollars, $ 2,000/year for 1 patient in Methadone maintenance, $ 6,000/year for 1 patient in a T.C.

(5) *Problems of staff-training of ex-addicts is carried out by whom?*

In most T.Cs in the US staff are not formally trained. What training there is "on the job". Staff are drawn from the ranks of patients and senior staff "train" them informally.

(6) *Some of those who are rehabilitated sometimes become "addicted" to the programme. Is this true elsewhere in the world?*

I agree that this is a problem. We have no solution but then we have not recognized this problem formally and consequently have not conconducted the obviously necessary research.

(7) *What is the optimum period of time the addict should stay in a T.C.?*

I think six months to a year - the better the first phase of the programme is; that is the phase linking the patient-client to the straight world - the shorter the length of stay.

(8) *Questioning the possibilities and values of using chemicals for withdrawal in T.C.*

The use of medically prescribed drugs to assist withdrawal presents no problem if staff is properly trained.

(9) *Detoxification in T.C. setting.*

Almost all drug dependent persons regardless of the drug or combination of drugs involved can be detoxified in a T.C. Withdrawal must be at slow rates however and staff must be trained. One also must have nursing staff circulate three times a day and at least twice a week medical visits from a physician.

REVIEW OF TREATMENT AND REHABILITATION MEASURES FOR DRUG USERS IN SINGAPORE

By

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In a matter of a short period (i.e. two years), the population of heroin users had grown by geometrical progression. In 1972 only 4 persons were arrested on heroin abuse. Two years later the figure had increased to 110; but it was not considered a major problem yet. It suddenly became a national problem in 1975 when 2,263 heroin suspects were arrested. In 1976 such suspects were arrested at the rate of 475 per month. It was then estimated that there were as many as 13,000 heroin addicts and abusers in Singapore at the beginning of 1977. Such magnitude of heroin users—an equivalent to 0.5 per cent of Singapore total population—called for a prompt and nationalwide measure first to contain the problem and then to mop it up. This measure was under the code name "Operation Ferret".

OPERATION FERRET

Operation Ferret was launched on 1 April 1977. This operation which is still going on, is an all out effort to tackle the demand side of the drug problem. The primary aim is to arrest heroin users rapidly enough and to detain them in drug rehabilitation centres more quickly than there are new heroin abusers being created. Thus in the year 1977, 6,719 drug addicts and abusers were admitted to the rehabilitation centres for treatment and rehabilitation. Of these, 6,490 abused heroin, 79 for morphine and 150 for opium.

Owing to the large number involved, it is clear that the task of rounding up suspects has to be shared amongst the Central Narcotics Bureau (CNB), the Police and related organisations such as the Vigilante Corps (VC) and the Special Constabulary (SC). All these enforcement officers form numerous drug squads. This Operation Ferret also includes the expansion of urine test facilities in the Department of Scientific Services and a Massive expansion programme for accommodation in the drug rehabilitation centres. When Operation Ferret was conceived there was only one rehabilitation centre, viz. the Drug Rehabilitation Centre at Telok Paku. This Centre had accommodation for 480 males and 120 females. Now there are altogether 5 drug rehabilitation centres bringing the total accommodation capacity to 4,980. At the present moment other centres are being developed. It is envisaged that eventually 6,000 persons may be under treatment and rehabilitation at any one time. Moreover, several other centres are also on the drawing board, if need be to bring the total accommodation capacity to the region of 8,000, to cater for the relapse cases and those who will have to be detained up to two years.

TREATMENT AND REHABILITATION IN THE DRUG REHABILITATION CENTRES

To stop the deteriorating situation in regard to the growing number of heroin users, a decision was taken at the end of 1975 to move the drug rehabilitation centre from St. John's Island to a former army camp at Telok Paku situated on the eastern part of the main island of Singapore Republic. The Telok Paku Drug Rehabilitation Centre became operational since March 1976. The former replacement therapy as the method of treatment was also abandoned. It has been replaced by the "Cold Turkey" treatment which in actual fact is detoxification without supportive medication. A more vigorous and comprehensive treatment and rehabilitation programme is also implemented amidst the more spartan surroundings.

The new programme consists of a comprehensive range of activities to keep the inmates in the centres meaningfully occupied from 8.30 p.m. to 5.45 p.m. daily. This programme was formulated by the Committee on Treatment and Rehabilitation of Drug Addicts. It comprises of 5 stages.

Stage 1

On admission to the drug rehabilitation centre, every inmate is given a medical examination. Stage 1 comprises of 7 days of mandatory detoxification during which period no medication is prescribed to the addict to assist his withdrawal - unless in the opinion of the medical officer it is necessary to save the inmate's life. Persons who are of 55 years of age or above as well as those who are medically unfit are exempted from undergoing this form of treatment.

Stage 2

Stage 2 covers a period of one week which is set aside for recuperation and re-orientation. The re-orientation is conducted by the staff to condition the inmates to be more receptive to the rehabilitation and to explain the dos and donts of the centres.

Stage 3

Stage 3 consists of one week of intensive induction to drive home to the inmates the evil of the drug habit, the realities of life and the meaningful part they can play and contribution they can make in our society. Starting from this stage of rehabilitation until the day of release, every inmate is free to attend weekly religious classes according to his personal choice. These classes are conducted by religious leaders of various denominations.

Stage 4

In Stage 4 the inmates are made to participate in military form of training to inculcate discipline and promote their physical well-being. This stage is from the fourth week to the end of the third month. The training tempo is gradually built up from light callisthenics in the beginning to an obstacle

course and jogging towards the latter part of the stage. As most of the drug users are lethargic and have led soft lives and lack self discipline, this form of training is found to be beneficial. During this stage also the inmates are required to take part in daily flag-raising ceremony, kit inspection and general cleansing chores.

Stage 5

In stage 5 which comprises the last 3 months of an inmate's normal six months stay in the drug rehabilitation centre, the inmates are put to work in industrial workshops to work for eight hours a day making an aggregate of 44 hours per week. This is to prepare them for employment. Past experience has shown that previously drug users who were able to find jobs upon their release, could not hold on to the employment because their capacity of sustained effort was lacking.

Review Committee

The Minister for Home Affairs appoints a Review Committee consisting of a Chairman who is a registered medical practitioner and five other members. Every inmate after being in the drug rehabilitation centre for three months will be reviewed by the Committee to consider the suitability for early release other than the normal six months detention. The Review Committee is also empowered to extend the period of treatment or rehabilitation for any inmate under consideration for a further period up to a duration not exceeding two years.

Aftercare

The objective of demand reduction for heroin has been achieved under Operation Ferret. It is now necessary to look into the problem of recidivism., i.e. the relapse of former drug users. It may be looked upon as a re-cycling of drug users after they have gone through treatment and rehabilitation programme at the drug rehabilitation centres.

Experience has shown how meaningful institution treatment and rehabilitation may be, without prolonged supervision and aftercare after discharge from the institutions is valueless in the combat against recidivism.

On 20 August 1976, compulsory supervision for a period of two years of those released from the drug rehabilitation centres was introduced. With statutory powers of supervision, Probation and Aftercare Officers are better able to keep track of the progress of the cases under their supervision. The supervisee has to comply with certain requirements, among which are :

(a) he must report to the Supervision Officer regularly

(b) he must allow the Supervision Officer to visit his home

(c) he must not change his residence without the prior authority of the Supervision Officer.

(d) he must not leave Singapore without the prior approval of the Supervision Officer.

(e) he must inform the Supervision Officer of any change of his employment.

(f) he must present himself for urine test every five days at the police station nearest to his home. (Started from 1 January 1978).

The Supervision Officers are actually Probation and Aftercare Officers who are assisted by Special Constabulary Part-Time National Servicemen (SCNS Supervision Officers). Most of these SCNS Supervision Officers are professionals or persons who hold managerial positions in their normal working life. They command positions of influence in their own sphere of work and they enjoy a certain status in the community. These are great assets in helping discharged drug users to find gainful employment.

The Singapore Anti-Narcotics Association (SANA), a voluntary or organisation has come forward to supplement the concern and efforts of the government in the field of personal care of rehabilitated drug users who are under supervision. SANA has mobilised various religious groups to set up Counselling and Aftercare Services for those under supervision. It has been estimated that a total of 1,500 volunteers holding 2 cases each will be required to service the caseload at peak. The response, interest and involvement of the religious groups have been most encouraging. Within a period of seven months (September 1977 to April 1978), 922 Volunteer Aftercare Officers from the various religious groups have been recruited, trained and selected to provide individualised counselling, guidance as well as assistance to the supervisees. It appears that there will not be too much difficulty in achieving the target figure of 1,500 Volunteer Aftercare Officers soon.

PRELIMINARY IMPRESSION

It is still too early to draw any definite conclusion on the effectiveness of the present regime of treatment, rehabilitation and compulsory aftercare, since these measures were introduced on 20 August 1976.

However, it is interesting to note that the present rate of recidivism is 44 per cent. It compares favourably to the estimated 90 per cent relapse rate before compulsory aftercare was introduced.

OVERVIEW OF DRUG DEPENDENCE TREATMENT METHODS AVAILABLE IN THAILAND

By

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At present the drug dependence problem in Thailand is very serious. The number of narcotic dependent persons requiring treatment is not less than 50,000. The availability of drugs is great. Opium is produced in the country's northern hills. Cannabis can be grown in many parts of the country. Almost pure heroin is easily obtainable in the cities. The drug dependent population is heterogenous including a number of different groups and patterns. The hill tribal population who are within or in the vicinity of the opium poppy cultivating areas are using and dependent to opium. The circumstances for its use varies with individuals and tribes. The traditional use of and dependence to narcotics in the low-land rural areas has been present for centuries; opium smoking is prevalent but rapidly increasing use of heroin is found in a number of studies. In the student population, the polydrug pattern with tendency toward experimentation among youth similar to those in western countries is evident. At the treatment facilities and correctional institutions, large proportion of chronic and relapsing heroin dependents are encountered. The pattern of use among the labour forces and among youths outside school is as yet not adequately studied. Little information is available concerning the use and dependence of certain drugs such as amphetamine-type stimulants and salicylates. Information concerning the nature and extent of the problem in the country is being gathered.

Treatment of drug dependent persons have been available both in the public and private settings. Considering the magnitude of the problem in the country, the available facilities are far from adequate. The knowledge and technology in tackling this problem is inadequate and inefficient at present. The poor treatment result has compounded the situation. The national planning in coping with this problem has gone through several stages of development from an haphazard beginning. In 1976 an Office of the Narcotics Control Board was established in the Office of the Prime Minister in order to coordinate various aspects of the activities. A sub-committee on treatment and rehabilitation was established to assist in the policy planning and to coordinate the efforts for the reduction of demand of drugs.

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* Presented by Dr. Charas Suwanwela

For decades, the treatment of opium dependent persons by traditional medicine was available at a number of non-governmental services, namely temples and practitioners. Remedies for termination of addiction could be found in the traditional medical teachings. Herbs were known to the Thai as well as to the hill tribes with anti-addiction property. Their efficacy has however not been proven.

While the Thai Government proclaimed illegal the smoking of opium in 1959, there were 70,985 registered opium addicts. A special hospital, Opium Addict Relief Station at Rangsit was set-up then for treatment of those addicts. The Department of Public Welfare and the Department of Medical Services shared the responsibility in the different stages of the service. Evidently the measure failed to rid the country of drug problem as intended. Since heroin was first found in the country in August 1959, the drug dependent problem has progressively become worse. Efforts have been made to reduce both the supply and demand sides.

Existing treatment programmes

At present treatments are available both in the scientific medical services and in the traditional healing institutions. The drug dependent persons seek treatment on voluntary basis. Heroin use is illegal and punishable according to Thai law but those seeking treatment at registered institutions are exempted. Due to the vast number of users and the difficulty in law enforcement, many heroin dependent persons are however at large and not well motivated to be rid of the habit. According to Dr. Somsong Kanchanahut and Dr. Tongchai Uneklabh, the reasons for heroin dependent person to seek admission to the Thanyarak Hospital which is a special hospital for the treatment of drug dependent persons were scarcely self determination to terminate the habit. Some sought admission for fear of police arrest. Waves of increase in applications for admission coincided with increased police suppressive activities. Some came because of pressure from their parents, guardians or teachers. A number of drug dependent persons merely wanted to lower the tolerance and enhance the effect of the drug. Medical complications and deterioration of health had let some to the hospital. According to the present legislation, the hospital has no authority to keep a patient in treatment against his own will. A large proportion of patients left hospital before the completion of the detoxification schedule of 10 to 14 days. At the Thanyarak Hospital, less than 10% of those completed the detoxification phase elected to enter the rehabilitation programme.

There are a number of reports describing the treatment facilities for drug dependent persons in Thailand and would therefore not be repeated here in detail. The methods available can be arbitrarily grouped as follows:

1. **In-patient treatment with methadone detoxification for heroin dependent persons.** This scheme is practiced at the Thanyarak Hospital, the Pra Mongkutklao Army Hospital and to a lesser extent at some military and some provincial hospitals. It is the main measure at the governmental facilities. The importation of methadone into Thailand

is under the control of the Dangerous Drug Board, Ministry of Public Health. Treatment services are required to register with the Ministry. In 1974 and 1975, the annual use of methadone in the country was between one and two kilograms.

Methadone is used to decrease or eliminate the withdrawal symptoms. Schemes of reducing dose over a limited period of 10 to 21 days are practised. It is supplemented with tranquilizers and other symptomatic remedies. Concomitantly psychiatric counselling is available at some hospitals. Other methods such as group psychotherapy are occasionally used. At the Thanyarak Hospital, facilities are available for rehabilitation after the completion of detoxification phase. Occupational and vocational therapy such as carpentry and agricultural work has been given to a number of them for a variable period up to several years. Preaching sessions by well respected priests and meditation lessons are also given. As stated earlier, only a small proportion of patients however elected to stay for the rehabilitation phase.

In the past eleven years since its inception, there were about 40,000 admissions to the Thanyarak Hospital. About half of them were recidivists.

Acupuncture was tried as another method for suppression of withdrawal symptoms by Dr. Aroon Showanasai at the Army Hospital and was found to be effective but it was too time consuming for the staff. The method was later abandoned.

2. **Outpatient methadone for heroin dependent persons.** In 1976 outpatient detoxification using methadone was initiated at a Bangkok Metropolitan Clinic and at the Police Hospital. It was also later provided at the Army and the Thanyarak Hospital. Patients are required to come to the treatment facility twice daily to take liquid methadone preparation for a period of 14 to 21 days. A number of schedules of reducing dosage are in use. Psychotherapy and psychiatric counselling is also available at some services. Variable period is required before a previously treated person is readmitted to the programme. An interval of 28 days is required for the Bangkok Metropolitan Programme. Since a number of patients are being retreated after relapse, the programmes are in fact providing methadone on periodic basis to them with little chance of complete abstinence. Experiences in this method are gaining and resetting of goal and strategy is under consideration.

3. **Traditional treatment programme for narcotic addicts.** A number of Buddhist temples which traditionally provide primary medical care to the villagers are involved in the treatment of addicts. Several variation of herbal and spiritual therapy are used.

A programme at Wat Pa Prag in Chiengmai and another at Wat Tam Khao Talu in Ratchaburi depends heavily on a herbal preparation which rendered the patient unconscious for several hours at the initial stage of withdrawal.

The famous programme at Tam Kraborg in Saraburi combines herbal medication which induces severe vomiting, a religious vow to stay abstinent, hydrotherapy and occupational therapy. The treatment requires 10 days of admission for the detoxification. Those completed this phase may elect to stay on and help in the activities of the programme. After some time, some who show strong motivation may be allowed to enter priesthood and join as a personnel of the programme. Since 1967 more than 12,000 drug dependant persons have been treated.

The Council of Social Welfare of Thailand has set-up a vocational training programme for those completed this temple's detoxification phase. A tailoring workshop has been established.

At Wat Sri Soda in Chiengmai, no herbal medicine is used: spiritual therapy is emphasized. The patients attend their own mocked funeral and rebirth. Intensive counselling and teaching follows. Symptomatic treatments including Dover's tablets are used.

4. **Opium detoxification programme for the hill tribes.** In 1976 the Narcotics Treatment Centre for Hill Tribes was established in Chiengmai by the WHO/UN/Thai Programme for Drug Abuse Control. Opium dependent hill tribal villagers are treated with schedules of reducing doses of tincture of opium. Symptomatic treatments and tranquilizers are also used. No concomitant activities and rehabilitation are available.

Similar treatment programme is occasionally given to hill tribal villagers by mobile medical teams who travel into the villagers.

Methodology for assessment of treatment outcome

It is extremely difficult to assess the result and advisability of a treatment model or programme. Follow-up of those who left the programme, is required. In most existing programmes, the follow-up rate is very low and therefore the assessment of result is difficult if not impossible.

The Institute of Health Research, Chulalongkorn University has undertaken a comparative study of follow-up methods, namely a mailing follow-up and an intensive outreach follow-up.

In the mailing follow-up, patients undergone treatment at Tam Kraborg over a four-month period were interviewed in an epidemiological study. According to their given address, a self report questionnaire in the form of return-mail postcard was sent to each of them at 3, 6, and 12 months following their discharge from the treatment facility. Care was given to keep identification at a confidential level. The preliminary results indicate that the mail follow-up may prove to be an economical mean with acceptable reliability.

For the intensive outreach, a team of field workers were recruited and trained to follow patients into their community and try to locate them or their family. It was found that for patients living in the provincial and

rural area, follow-up was possible. In Bangkok where patients are mainly living in the slum areas and are extremely mobile, the follow-up is more difficult.

For some urine samples were also collected but it was found to be creating distrust of the field workers and interfere with his information gathering.

The intensive outreach was proved to be possible, although it is very costly and requires dedicated workers.

In small isolated communities such as the hill tribes, it is possible to assess the opium use and dependent state in the whole village. The method also provides more insight into the socio-cultural setting behind the problem and its bearing on the result of treatment.

Results of existing treatment

Limited information is available concerning the results of present treatment programmes. In an interview of addicts in the Correctional Institutions and Tam Kraborg, Poshyachinda et al gathered information about the abstinent period following last treatment and found that those who stopped taking the drug by themselves had a longer abstinent period. The rate of relapse was not much different between those treated at the Thanyarak Hospital and at the Tam Kraborg Temple. Dependence on heroin had a considerably higher rate of relapse than that on opium. In a similar study carried out at treatment facilities, Chatiyanonda et al found that 60% went back to drug within one month and 88% within six months. These figures are not true result of a treatment programme because only those continued to have trouble were included.

In the follow-up study of Tam Kraborg patients by intensive outreach, about 2% of those heroin addicts accounted for were dead. Among 232 patients accounted for in the follow-up, 104 were still abstinent 3 months after discharge.

In a comparative study of family and environmental setting of two groups of addicts who had an abstinent period longer and shorter than three months, it was found that there are distinct differences in the personal characteristics as well as the economic and attitudinal status of his family. The better group had a significantly larger proportion of an understanding family member with more knowledge of drugs. While in the group with shorter abstinent period, the family would tend to be rejecting even though they may be supporting financially.

Community treatment programme

The Institute of Health Research has undertaken a study of a number of hill tribal villages where information on opium users and dependence as well as health status and related socio-econmic status were gathered. The opium dependent persons were identified. Their history and socio-cultural circumstances were accounted for and the cause of dependence

was assessed. An intervention programme is undertaken for the whole village. Goal and strategy for the community as well as for each individual was set. The result of the programme is closely monitored.

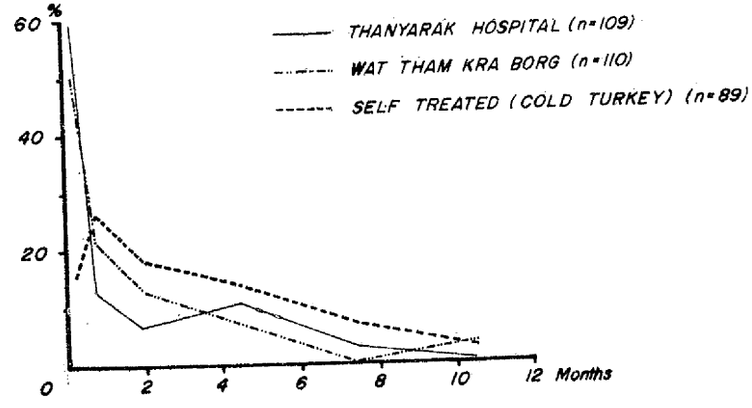
Conclusion

The present stage of our knowledge concerning the treatment of drug dependent persons is still far from one with consistently acceptable results. This is perhaps the consequence of our lack of understanding of the nature of drug dependence and its underlying factors. It seems clear now that a variety of treatment modalities would be more likely the answer than an ideal uniform method of treatment. The modality needs also to take local socio-cultural setting into account.

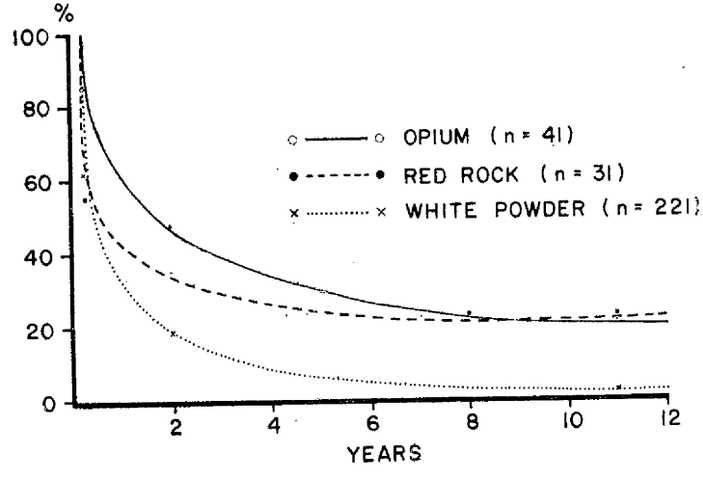
For Thailand the drug dependent population is heterogenous and requires treatment models to suit the need of each community and each individual. Assessment concerning the possibility, goal, and appropriate approaches is an essential step in the management. Surprisingly a simple detoxification was found to be effective in giving prolonged or total abstinence in a number of selected dependent persons who might be ready to change their life style. In general, however, spiritual, occupational, economic, psychological and societal measures are required following detoxification.

CONVICTS OF DRUG OFFENCE

DURATION OF ABSTINENCE AFTER LAST TREATMENT FROM VARIOUS TREATMENT CENTERS

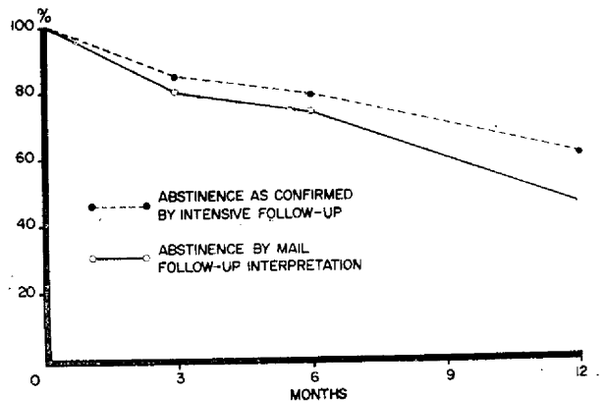


DURATION OF ABSTINENCE AFTER LAST TREATMENT



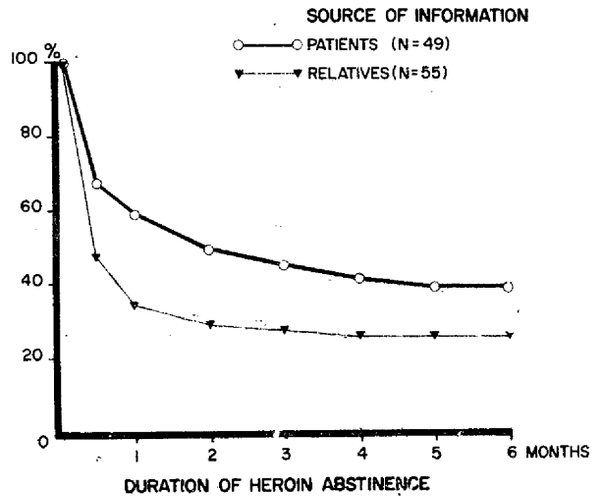
BUDDHIST TEMPLE TREATMENT(TAM KRA BORG)
MATCHING MAIL RESPONSE WITH INTENSIVE FOLLOW-UP

VALIDATION OF MAIL FOLLOW-UP INTERPRETATION OF
ABSTINENCE DURATION (HEROIN USERS : N = 52)



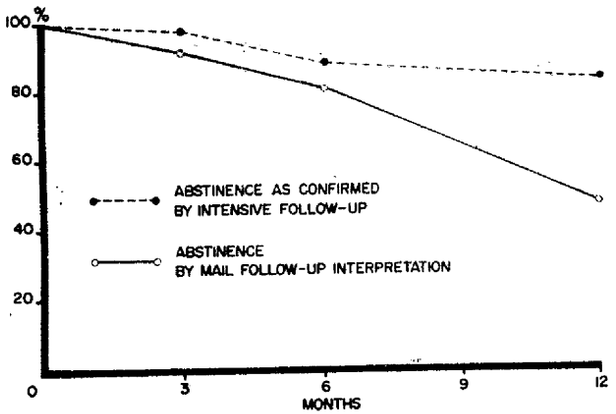
BUDDHIST TEMPLE TREATMENT (TAM KRA BORG)
INTENSIVE CASE FOLLOW-UP

DURATION OF HEROIN ABSTINENCE



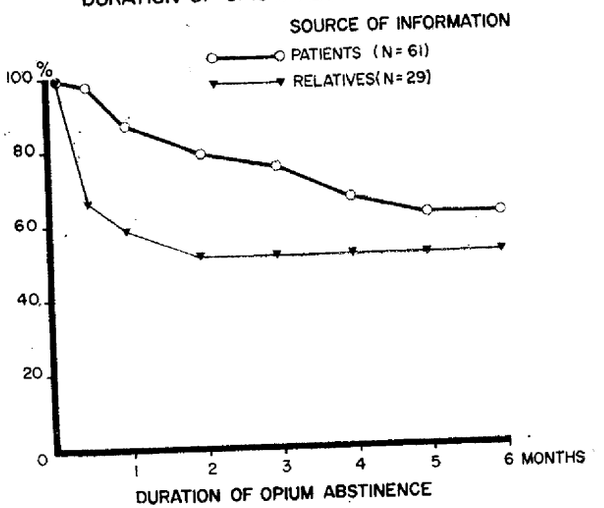
BUDDHIST TEMPLE TREATMENT (TAM KRA BORG)
MATCHING MAIL RESPONSE WITH INTENSIVE FOLLOW-UP

VALIDATION OF MAIL FOLLOW-UP INTERPRETATION OF
ABSTINENCE DURATION (OPIUM USERS : N = 38)



BUDDHIST TEMPLE TREATMENT (TAM KRA BORG)
INTENSIVE CASE FOLLOW-UP

DURATION OF OPIUM ABSTINENCE



THE CHANGING ROLE OF THE THERAPEUTIC COMMUNITY IN TREATMENT AND REHABILITATION OF DRUG DEPENDENT PERSONS

By

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This paper sets out to discuss the role of Statutory Services and Voluntary Sectors in the treatment of drug abuse, but first, I feel it is relevant to briefly outline the recent history of the drug problem in England, for history determines the nature of this problem and the way it is tackled. Moreover, it is history that has shaped our view of the addict today, and what we mean by rehabilitation.

There has been drug abuse in England for many years, but this for a long time was confined to an insignificant number of people who might have been prescribed opiates on a therapeutic basis and subsequently become addicted. These few hundred drug-takers were predominantly middle aged and middle class and presented no threat to society: there was ostensibly no opiate problem.

In contrast to most other countries, the medical establishment had a tolerant attitude towards maintaining these individuals on drugs, a function that was left almost entirely in the hands of the general practitioner. Addiction was seen as a form of sickness and the addict was seen as an unfortunate person rather than a wilful deviant, someone with a medical condition over which he had little real control. The Rolleston Committee (1926) provided legitimisation of this viewpoint when they endorsed long term maintenance prescribing of opiates, in at least some circumstances. The current attitude would seem not to have been dissimilar to that existing in the United States before the Harrison Act where addicts were regarded with sympathy and not fear and condemnation.

This situation changed somewhat in the 1950's, when a growing number of Canadian and American addicts came into the country to avail themselves of England's more liberal services. They were largely concentrated in the London area and exclusively the responsibility, at that time, of one doctor, and probably tended to meet together on the fringes of London's club society. Also in the late 1950's and early 1960's, in the wake of American 'beat' literature, there was a growing awareness of drugs throughout England which grew as they became celebrated in Rock-n-Roll and formed part of the Flower Power sub-culture.

In particular there was an increasing abuse of amphetamines, and the practice spread to the provinces. Moreover, the concentration of West Indian immigrants into small pockets in the inner city areas also led to the greater importation of cannabis and the subsequent use by the indigenous population.

By the mid 1960's, the prescribing of opiates, cocaine and methylamphetamine, had increased alarmingly although this was concentrated in the hands of no more than a handful of doctors in central London. The addict had to pay for his prescription and, in turn, sold a proportion of his drugs in order to raise the money; a transaction that inevitably led to the spread of addiction. Subsequently a number of criminal prosecutions were brought against the offending doctors, on the grounds that they had over-prescribed and profited through their activities.

The Government's response to this situation was to reconvene the Brain Committee with the brief "To consider whether, in the light of recent experience the advice they gave in 1961 in relation to the prescribing of addictive drugs by doctors needs revising and, if so, to make recommendations." As a result of its recommendations the Department of Health and Social Security set up the Drug Dependency Units.

These clinics were intended to be largely multi-disciplinary but under the control of a Consultant and based within the established facility of a hospital. Addicts were to register with the DDU within their geographical catchment area in order to obtain a prescription (at no cost through the National Health Service), and the DDU in a number of cases was to have a limited number of beds for in-patient withdrawal. In the London area alone, 14 DDU's were established and two of them (University College Hospital and the Maudsley Bethlem Royal Hospital) had research facilities included. Their total capacity was somewhere in the region of 2,000 patients. One could say that from being previously concerned only with the welfare of his patient, it could now be argued that the doctor now also became an agent of social control.

For these clinics were set up with the intention of stopping indiscriminate prescribing by a small number of doctors, by limiting the prescription of heroin and cocaine to specially licensed doctors only. It was hoped that this would wipe out the existing black market and so control the spread of opiate abuse. Secondly, clinics were to treat and, if possible, cure the patient.

Evaluating how successful the clinics have been in achieving their primary goals presents some difficulty (and would depend on who is doing the evaluating: there have been major differences of opinion between the voluntary and statutory sectors in the past). It is impossible to predict, for example what might have been the situation if the clinics had not existed and market factors alone determined the size of the problem.

The most recent Home Office statistics of addicts give a figure of 1972 known to them to be receiving drugs at 1st January 1975, (figures for 1970-75 broken down into type of drug, age and sex of addict, length of time known to the Home Office, and numbers of new addicts and reason for those no longer recorded, are given in the Appendix). But while there is a need for caution in interpreting the available indicators there is also considerable evidence that many illicit misusers of opiates are not notified to the Home Office as addicts. It has been suggested by Blumberg and Dronfield

("Nomination Techniques in the Study of Largely Invisible Groups: Opiate Users NOT at Drug Dependence Clinics", 'Social Science and Medicine', 1975) that the non-clinic, and hence un-notified, population of addicts in Britain is about as large as the clinic population. For instance, 64% of the 148 persons misusing drugs intravenously who made contact with medical agencies in Bristol in 1971-73 were not notified to the Home Office. ("A City looks at its problems of Drug Addiction by Injection", Bishop, Cave, Gay and Morgan, 'British Journal of Psychiatry', 1976). This is in part because some doctors are disinclined to notify the Home Office of those they dont accept for treatment on the grounds of confidentiality.

It would seem that the clinics have succeeded in slowing down the growth of illicit drug traffic, certainly in comparison with some European countries e.g. Holland, Germany. However, the black market still exists and therefore the supply of drugs is not controlled. Furthermore, most addicts are outside the clinics' influence because they prefer to go to the black market as they resent the demands made on them by the clinics (a very small proportion of our intake at Phoenix House obtain their drugs from a DDU). Finally, the clinics have had very limited success with rehabilitation, tending (as was the accepted medical view in the past) to create and sustain long term dependency.

Some doubts must also be raised as to the effectiveness of the clinics in "stabilising" drug-takers within the system. The DHSS Advisory Council on the Misuse of Drugs, Treatment and Rehabilitation Working Group's first interim report of September 1977, reveal that "a study by Dr Martin Mitcheson (unpublished) comparing patients prescribed injectable heroin with those offered oral methadone only, showed no significant difference between the two groups in terms of their use of unprescribed narcotics or their consumption of non-opiate drugs (e.g. barbiturates/amphetamines). This supports the view that the existence of authorised sources of supply does not prevent the parallel existence of a criminal black market. It may also serve to show that illicit users, and particularly young illicit users, are not receiving adequate attention, and lack encouragement to come off drugs, and in our further study we need to consider whether existing treatment facilities are appropriate for this kind of person".

A description of what could be called the statutory response to drug-taking would be incomplete without some reference to the role of the Prison Service. Although the policy of prison containment of drug and drug related offenders, or the notion that prison sentences somehow deter others from becoming addicted, raises certain social and moral questions, these are outside the scope of this paper and it will suffice to say that some prisons do provide a limited but useful detoxification resources.

Given the illegal nature of most drug abuse activities, they will inevitably see large numbers of people in the course of their work. For, example, Brixton, the principal remand prison for the Greater London Area, is for many addicts outside of the clinic system, the only source of immediate help available.

It is difficult to give precise figures for addicts entering H. M. Prisons, as often the actual offence is some form of theft, and if the individual is not suffering from actual withdrawal symptoms or elects to remain silent, he may go un-noticed. Notwithstanding this, in 1976 40% of all new notifications in the London area, were made by Prison doctors.

Although, as previously stated, addiction has been around in England for some considerable time, it was not, initially, a source of widespread public concern. This changed dramatically, when the possibility arose of the American experience repeating itself, and drugs became a source of national anxiety. In 1968, the Advisory Committee on Drug Misuse, successor to the Brain Committee, reported, "Rehabilitation principally involves persuasion to accept help, removal of physical dependence, and the longer process, removal of psychological dependence. Simultaneously, with all these processes, attention must be paid to the requirements for the eventual rehabilitation of the addict".

Although the majority of clinics were set up with facilities for in-patient withdrawal, there was generally speaking, no considered approach to long term rehabilitation. It was therefore left to voluntary organisations to fill this gap. In the case of residential facilities, the sponsoring bodies could be said to fall into the following categories: independent organisations running small facilities on 'democratic' lines, religious organisations such as Life of the World, New Life Foundation and the Coke-Hole Trust, and Houses run along the same lines as the American rehabilitation programmes such as Synanon, Daytop and Phoenix House in New York. All have two factors in common; they insist on the resident being drug-free and they all have some therapeutic content to their practice.

Falling into the grey area between the clinics and the drug-free programmes is Roma, an organisation which exists to provide accommodation for using registered drug addicts. England would prefer, it would seem, a diversity of approaches, and since the drug problem has not grown on anything like the scale seen elsewhere, all these residential facilities have remained fairly small.

By far the major presence in the drugs rehabilitation field, is posed by the 'concept' houses. The first two projects to be established in England were Alpha House and Phoenix House, which were opened in 1968 and 1969 respectively. They were followed by the Ley Community, Suffolk House and Coolemine in Southern Ireland. They are loosely bound together by the Association of Concept Based Therapeutic Communities, which holds regular but informal meetings. Although modified over the years by exposure to the English cultural scene, the English houses are, in essence, sufficiently like their American counterparts, and as much has been written on this subject, I do not propose to talk specifically about the actual structure of the programmes. What I feel is more interesting is their impact on the drug scene in England, and their ability to polarise opinion amongst workers in the drugs field and the general public at large. As when the Mayflower originally docked in Virginia, the natives were probably initially curious but after reflection, not ecstatic, likewise the

English, with their memories of fascism, and profound dislike for apparent totalitarian organisations, were at first interested but then not enamoured of heirarchal structures, haircuts, pullups and bald heads. However, sufficient publicity had surrounded the apparent success of the American programmes, for this to be seen as an answer to the English problem.

Phoenix House in England was largely the inspiration of an English psychiatrist, Dr. Griffith Edwards, Director of the Institute of Psychiatry, London. The Project was initially sponsored by the Attlee Memorial Foundation, who arranged for a graduate of Phoenix House, New York, and his wife to begin the English programmes in 1969.

Although the community had its early, undeniable successes, as a public relations exercise, it might well be considered to have been a disaster. It was seen by both drug-takers and referring agencies alike, to be over disciplined and oppressive. Moreover, the Project increasingly came to rely on legalistic sources for referrals, and whilst there is a clear need for a viable alternative to prison, there is a danger that one can be seen simply as an extension of the penal system. This might additionally create some conflict in terms of how the staff interpret their roles.

It would seem that unless rehabilitation can promote itself as an attractive and meaningful proposition to clients, and avoid the high fall-out rate associated with this type of programme, it can make very little real impact on drug abuse. In the final analysis, a programme must surely be measured by its effectiveness.

Probably, because the English addict is more cushioned against the realities of his addiction by the provisions of the Welfare State, and in particular, the clinic system, he is less inclined to pursue a course of action that he might think of as being punitive, and will exercise his right to choose an easier option. Consequently, the number of voluntary admissions have never been high. On the other hand, a significant number of admissions to Phoenix House were clearly people who were virtually following rehabilitation careers, and had been through a variety of residential facilities before. In fact, it is probably generally true that the English addict is less criminally motivated, and probably more passive than his American counterpart. It was in transplanting the American experience into English terms, that caused the early problems within the community. At a meeting recently, in London, one psychiatrist jokingly described Phoenix House as 'that community where they confront each other in American'. Although perhaps unfair, this is not entirely that wide of the mark, and not only the House vocabulary but also its expectations were largely American influenced.

The Programme was originally started for Metropolitan heroin addicts, whereas today the clientele is younger, more likely to come from the suburbs, and predominantly multi-drug abusers. There is a danger that unless a community is prepared to reappraise its work in the light of changes on the drug scene, it will cease to be an effective way of helping human beings. At Phoenix House, we isolated the characteristics that we felt were most inproductive in terms of the programme meeting its aims and

goals, e.g. to rehabilitate the maximum number of people. They were as follows: there was undue emphasis on punishment, and far too few constructive rewards. An unreal sense of elitism surrounded the ex-addict, with the inference that people who were not of this ilk were not worth knowing. Little apparent importance was attached to the addicts family ties, even though this might be a mutually supportive arrangement. A resident in the Programme was allowed little or no contact with the wider community, with the result that when in re-entry, the resident was socially isolated. The programme tended to be far too inward looking, and was unable to make use of facilities existing in the local community, such as youth clubs, evening classes, community centres etc. Far too much attention was focused on the value of the Encounter Group, while the usefulness of other group work methods were seldom explored. One could expand on this list still further, but it is probably enough to say that the Programme faced a real danger of becoming too narrow in its thinking, that militated against successfully rehabilitating people. In a perverse sort of way, it was becoming as much an agent of control as other facilities for drug-takers, and not an agent of social change. The programme characteristically sought to explain its failure away; an example of this, to my mind, was provided by a researcher working at Phoenix House some years ago. He discovered that a high proportion of late programme drop-outs remained drug free, so they were promptly claimed as successes which in their own terms they, undoubtedly, were. However, it seemed to be a very dubious practise, as the programme stands, to reassure itself with these inverted statistics, especially as they outnumber programme completers.

Therefore, while retaining the essential nature of the structure, and most of the disciplinary procedures inherent to this type of community, less emphasis was placed on confrontation. We began to deploy a wider range of group techniques, principal amongst them being the use of psychodrama and video recording. Alongside this, we have opened the House much more to outside influence, and residents are encouraged to do voluntary work in the local community during their programme. Much of the real decision making has been restored to the residents, particularly those decisions relating to activities, and ways of dealing with recurring problems. Incoming mail, previously screened by staff, is now the perogative of a letter reading group, with the recipient sharing the contents with his or her peers. Bald heads have not been given in the community for some considerable time, likewise signs are now very rarely used and the terms 'haircut' and 'ramrod', amongst others, have been dropped from the House vocabulary. However, although we are at pains to change the personality and practises of the Project, we feel the therapeutic community is still one of the most creative and flexible methods of dealing with the problem of drug abuse. It will continue to be a viable proposition just as long as it is able to keep pace with changes in society, and more particularly in the changing picture of drug abuse.

Finally, it is encouraging in England that there is a growing awareness of the various ramifications of the drug problem; increasingly the activities of the multi-national drug companies are being criticised. The wholesale prescribing of sleeping pills and tranquilisers as a universal panacea is being

discouraged. The experience of one lady I met at a recent conference, perhaps provides some idea of the way forward. She had started a ladies' slimming club, then discovered that all of its members were prescribed valium. This, of course, was by no means coincidental, and after cajoling her members to give up their drugs, they transformed the club into a healthy living group. Perhaps until society looks to its own health, it will not sufficiently change the problem of drug abuse.

APPENDIX

STATISTICS OF DRUG ADDICTION IN THE UNITED KINGDOM

TABLE 1 Addicts known to the Home Office to be taking drugs by type of drug, origin, age and sex.

DRUG ADDICTS as at	1970 31.12.70	1971 31.12.71	1972 31.12.72	1973 31.12.73	1974 31.12.74	1975 31.12.75
TOTAL NUMBER	1426	1549	1615	1815	1972	1954
DRUGS*						
Number taking heroin	437	385	338	378	392	316
,, ,, methadone	991	1160	1278	1439	1552	1543
,, ,, cocaine	57	58	46	51	47	23
,, ,, morphine	105	100	89	83	82	70
,, ,, pethidine	77	70	59	50	61	62
AGES						
Under 20	142	118	96	84	64	39
,, taking heroin and/or methadone	136	111	95	83	61	37
20-34	958	1122	1220	1414	1539	1534
taking heroin and/or methadone	920	1087	1195	1375	1484	1440
35-49	112	112	118	136	163	169
taking heroin and/or methadone	69	73	86	95	114	121
50 and over	195	177	165	180	198	194
taking heroin and/or methadone	39	35	36	42	44	42
Age Unknown	19	20	16	1	8	18
taking heroin and/or methadone	10	9	5	1	3	7
SEX						
No. of male addicts	1051	1133	1194	1369	1459	1438
No. of female addicts	375	416	421	446	513	516

*These figures refer to drugs used alone or in combination with other drugs. Thus, an addict using both heroin and cocaine will be included under both drugs.

TABLE 2 Addicts known to the Home Office to be taking drugs by new notifications and number no longer recorded as addicts

	1970	1971	1972	1973	1974	1975
1. Addicts known to be receiving drugs at 1. Jan.	1462	1426	1549	1615	1815	1972
2. Notifications by medical practitioners of:-						
a) new addicts placed on the Index during the year	711	774	799	807	876	926
b) Addicts who were previously on the Index left it and have rejoined	484	562	586	599	566	532
3. Addicts no longer recorded on current Index at 31.Dec.						
a) removed by reason of death	74	58	65	61	77	69
b) admitted to penal institution				403	380	483
c) admitted to other institution	1157	1155	1254	34	7	1
d) no longer seeking treatment				708	821	923
4. Addicts known to be receiving drugs at 31.Dec.	1426	1549	1615	1815	1972	1954

APPENDIX

ADDICTS KNOWN TO THE HOME OFFICE TO BE TAKING DRUGS BY LENGTH OF TIME KNOWN TO THE HOME OFFICE

UNITED KINGDOM - NUMBER OF ADDICTS

Length of time Addict known to the Home Office	As at 31.12.70	As at 31.12.71	As at 31.12.72	As at 31.12.73	As at 31.12.74	As at 31.12.75
6 months or less	127	182	154	160	181	136
Over 6 months and up to 1 year	119	98	124	130	125	133
Over 1 year and up to 3 years	614	405	363	441	418	406
Over 3 years and up to 5 years	291	524	514	332	347	333
Over 5 years and up to 10 years	174	225	341	662	787	822
Over 10 years and up to 20 years	66	78	81	67	89	104
Over 20 years	28	27	28	23	25	20
Unknown	7	10	10	—	—	—
Total	1426	1549	1615	1815	1972	1954

TOWARDS A MORE RADICAL THERAPEUTIC ENVIRONMENT

By

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I count it a great privilege to be invited to present this paper to such an important conference as this. I am aware as I do so that my paper can only be at best an attempt to contribute anything of practical value to the findings of this group, coming as I do from a distinctly Western background and in so far that our programme is spiritually based on historically Christian influenced society. To this extent therefore there may be difficulties in relating all that I have experienced to Southeast Asia and it's multi-religious culture. There are however elements in the task of rehabilitating drug dependents which are common to all who work in the field no matter where in the world this work is done.

I will therefore try to address myself to the following headings :

(1) How drug Free Rehabilitation evolved in the U. K.

(2) The Object of Rehabilitation.

(3) Necessary Elements in Rehabilitation.

(4) The Life for the World Therapeutic Community.

INTRODUCTION

First of all, it may be helpful if I were to share with you something of my experience:

My background is non-medical, nor was I trained as a social worker until I came into this work I was a Minister of a Church in Southeast England.

In 1964, I moved to London where I became involved in chaplaincy work in the West Park Psychiatric hospital, Epsom Surrey among addicts under treatment in the drug unit. In those days the Church was singularly uninvolved in caring for addicts and the official hospital Chaplain avoided the unit. I worked at West Park and St. John's, Lambeth for two years with Dr. Peter Chapple who was one of the medical pioneers in the field of medical and psychiatric treatment in the U. K. In 1966 I was appointed onto the management Committee of the Chelsea Addiction and Research Institute under Dr. Chapple's medical direction. This Institute was the first of its kind in England and provided medical and psychiatric treatment for addicts away from a hospital environment. It also provided out-patient treatment which included group counselling and follow up. I was the chaplain

of this unit and was very active in the treatment and therapy programmes. The Institute was one of the first units in the U.K. to use methadone, or the British equivalent, Physeptone as part of the treatment programme.

It was obvious that something more than treatment in a medical unit was needed as all that was happening was that addicts, after their treatment was complete were returning to the streets and to drugs, and a vicious circle of recurring addiction was the result. Those who were maintained on Physeptone were little more than "frozen addicts". In 1967 we formed Life for the World Trust and opened our first centre in the West of England, I will say more about our programme in a moment.

The Evolution of Drug-free Voluntary Rehabilitation

David Tomlinson has already described the way in which the drug free programmes evolved in the U. K. Ours was one of these and we were able to open not without considerable discouragement from the medical establishment and the relevant Government departments. I will try to expand on this:

In the 1960's drug addiction was seen largely as a medical "problem" and as such non-professionals were discouraged from getting involved in aftercare. The rehabilitation study group of the Interdepartmental Committee on Drug addiction (The Wayne Committee, formery the Brain Committee) were not convinced that non-professionals could contribute very much outside of the hospital or medical environment. Organizations like my own were not visited by investigators from the Committee when they were considering their report.

Psychiatric technique and the use of drug related therapy was seen as the only effective means of treatment and the psychiatrist was thought of as "all powerful". There was, apart from a few significant exceptions consistent resistance from the medical establishment to a non-medical approach. This resistence had to be broken down before any Government assistance was forthcoming to voluntary organizations.

Yet, strangely the reasons why young people used drugs and became dependent upon them, whilst hard to define at the best of times certainly hasn't been demonstrated as being based on medical and psychiatric grounds alone. Is there not some agreement that there are at least other factors in the making of an addict which call for many disciplines to be involved in finding a cure? Strangely, spiritual ones, perhaps because they belong to the rather hazy area of the personality, are hardly ever referred to by professionals yet the addictive personality seems to be very aware of the "unseen" and is only too often aware of 'other worldly ' issues which, certainly in the original "hippy" culture and their use of psychoactive substances tried to experience because they were disillusioned by the industrialized, power and money motivated society they were trying to escape from. To me the drug user is seeking for deeper experiences, more satisfying ones which, if any approach to treatment denies him will leave him "withdrawn" but unhealed!

Recognizing the important part the doctor has to play in the total healing process, there must come a time when he hands over the work to others who can offer something "more" to replace the huge gap left by the removal of drugs. It was the conviction of this that made many, not only those who shared my more "religious" view point but many within the Therapeutic Community movement turn to non-medical means of offering on-going treatment and rehabilitation to the growing numbers of needy young people who were discovering that drugs in reality had nothing to offer but despair.

The Objectives in Rehabilitation

There are different ideas among all of us as to what constitutes a "successful" rehabilitation programme. I will discuss mine in a moment. However, as I see it, there is general agreement that the one time addict must be guided away from his dependence on drugs to a free and fulfilling new life. Easier said than done, I know, but all attempts at rehabilitating him, must aim towards total change. Some are content that such change is that the one time user is 'off' heroin even if he uses marijuana from time to time, whilst others consider him incomplete if he even drinks alcohol. I certainly look for something more than a "functioning" ex-addict, but believe that real success can only come, not when the therapist or statistical expert pronounces the "patient" healed, but when he knows it for himself deep down inside and acts accordingly.

The Elements Necessary in Rehabilitation

Any approach to rehabilitation must have certain common ingredients which it shares with others for example, although in many ways the life for the World Programme differs sharply with, "Phoenix house" and other concept houses, there is a similarity in basic issues which at times makes me wonder at the almost "miraculous" way our aims have come together, even though our basic philosophies are so different, and until the ICAA drew the Therapeutic Communities together under their TC section we had never sat down at the table together. (And I would like to pay tribute to Dr. Eva Tongue and ICAA for making the impossible happen in bringing us together, for much hard work behind the scenes has gone on, and continues even now, to make the first World Congress in Sweden possible).

Here then are those ingredients, or steps, I feel are necessary to make the rehabilitation of a one time drug dependent personality work:

(a) Abstinence from Drugs

An obvious but difficult first step. Addicts in a rehabilitation programme, whilst possibly "off" drugs in the physical sense, usually spend hours every day using drugs in their minds. They talk to others in the programme about drugs and continually refer to the "good old days". The continued mental use of drugs must be rejected if they are ever to begin making progress. It

is possible for one to go through a rehabilitation programme apparently successfully, but giving a lot of thinking time to the past and when he leaves going right back to drugs with the resultant dangers, which because of physical abstinence can often lead even to death by overdose, and we have had sad experience of this. This mental use of drugs may be a case for psychiatric care at the rehabilitation phase, but the doctor, by his very presence can only prolong this dependence on drugs. In our centre we have experienced many problems caused by the most innocent excursions to the doctor's surgery for non-drug related ills, just because the mere sight of rows of bottles in the dispensary or a hypedermic syringe can 'turn on' the mental addict. Dental treatment also causes similar problems in the early stages. The help of a really cooperative doctor is vital.

(b) Rejection of the Drug Culture and the Past

Closely connected with the above, is the need for an honest rejection of the past. Addicts habitually live in the past. In the Bible there is a verse which wisely says, "forgetting those things which are behind, let us go on unto perfection!" we seek to make this a workable theory in all we do. For this reason the resident in a therapeutic programme must be encouraged to see that his dependence on past relationships, attitudes and life style must be put behind him. He musn't rely on the old things, even his choice of certain music and clothing must change. This creates initially a certain state of insecurity as one life style is rejected for another and a lot of care and understanding must be given at this vital stage, but the change must come. At present in our community we have a man of 28 years of age who was part of the early "Hippy" movement in England. The biggest crisis he ever had to face with us was having his hair and beard cut, and even now his hair touches his shoulders! After many months he still holds on to much of his past and only last week said to me: "I'm like a man standing on a sinking ship which I know will let me down, yet even though I can see the life boat, I'm afraid of it!" Until he does let go of the past, he cannot go on and is afraid of the real world outside.

(c) A New Dependence and Thinking Style

I have already referred to rejection of the past and thinking new thoughts naturally follows on from that. Something good and wholesome must replace the negative and destructive aspects of the one time 'junkie' culture. I 'm not sure if my colleagues in the 'concept' houses would agree with me, but a new dependence needs to be created within and I don't believe that self dependence alone is sufficient. Building faith in oneself is a key ingredient in the therapeutic methods used in Therapeutic Communities but this faith alone can still let one down, rather like a ship anchored to itself which is still liable to drift. I firmly believe

that a simple faith in something or someone else is the key to real liberty, it can be a friend, a community or a wife or husband, but if the ex-addict can find a spiritual faith, then he has something which goes with him and remains, long after he has left the security of the community and strength of a human companion.

(d) **New Friends and Affections**

(e) **New Ambitions**

I have placed these together, mainly to save time as they are fairly obvious. Making new friends or developing family relationships is a key issue because addicts tend to have few if any friends outside of the drug taking circle. I'm not sure either if fellow ex-addicts or members of the community make the best circle of friends and as such in our setting an ex-addicts group seems to me to be counter-productive, maintaining the links with the past. Being a church related community is helpful in our case as members of Christian communities are always ready to provide homes and caring friends.

To encourage new aims and ambitious needs to come early on in the rehabilitation process. Addicts are, generally un-ambitious and some therapists even discourage ambition in the light of the capitalistic rat-race of the Western Society in which we work. However hopes and aims for the future provide direction, so vital to the emerging ex-addict and the important self confidence a good Therapy seeks to create.

(f) **A Fearless Attitude to Life**

I have, by making this list of elements in rehabilitation tended to sound as though it is definitive, however, I wish to emphasize that whilst the list is by no means complete and there are many other aspects to be considered, these are my own ideas and I don't speak for other programmes. However, I do believe that within these headings are contained all the most important factors and discussion can reveal more. The ideal therapy produces out of a one time mixed up and shattered personality, a precious individual, valuable to himself and others, with a fearless, if cautious attitude to a new life in a substantially new world and this attitude must be created for rehabilitation to be complete. One of our graduates once said, and this sums it all up in my view: "Once I only had a past to be ashamed of, now I have a future to be excited by and to experiment with".

The Life for the World Approach

I have used the word "radical" in the title to this paper, because the community which evolved over the 13 years since I began working with addicts was to me extremely radical. From a highly staff dominated programme with us workers "doing good" to those addicts who came to us

for help we have, inspired by the Therapeutic Community developed into a resident run programme where the staff are now in the minority and also open to being challenged and criticised by the community.

There are many ways in which our community is similar to 'concept' based houses. The differences being that the central means of therapy is not based on the encounter group. In fact we do not essentially have one, preferring to encourage individual, self, or if you like, spiritually motivated encounters. However we do have a twice daily Community Meeting where residents are encouraged to speak openly and honestly. Swearing is discouraged as is any antisocial behaviour, and people are encouraged to practise what Professor Hobart Mowrer describes as "exomologesis", something common in the early christian groups during the early centuries of Christianity. It means to practise transparency out of which comes another technique with a Greek word, "Noutheseo" meaning to lovingly confront one another.

As old fashioned as it may sound, we do encourage the practice of "brotherly love" and forgiveness as the key to all problems. Hence, there are no "learning experiences" as in other Therapeutic Communities with the wearing of one's misdemeanour on a placard, nor have we ever practised the haircutting or bald head treatment in our programme. This seems to work for others, but we did not feel that it was consistent with the Christian ideal of forgiveness and making a person feel forgiven.

Our daily programme includes, as I've said already, two community meetings, small group discussions, centred sometimes around Bible Study. Visitors come to take these groups at times and our liaison probation officer comes regularly also to take part. Work assignments include maintenance of the centre, cooking and gardening. we also have a pottery and printing press which from time to time is run by residents.

Residents stay with us for up to 18 months and at present two are staying longer to help as voluntary workers whilst working locally, one as a chef in a restaurant and the other on a farm, both skills they acquired whilst they were in the programme.

Our numbers are small, with our maximum community never more than 22 members. This reflects as much as anything upon the size of the drug problem in the UK, although not everyone chooses a religiously based programme, and also our means of communication are inadequate. Nevertheless over 10 years we have had 500 residents with us, and as yet although we have no reliable method of determining a success rate, many of those who keep in touch are doing well after many years and working in areas which cover a wide spectrum of activities.

Conclusion

This then is a very inadequate attempt to talk about one type of rehabilitation approach, it's by no means perfect and we still have much to learn, the greatest imperfection I often feel is in myself, and failures are usually due to our own mistakes as workers I think.

However, rehabilitation is a vital subject and whatever means may be employed, and whatever approach is favoured by those who report on this conference, I trust that the outcome will be more caring, life changing rehabilitation efforts in S.E. Asia resulting in many being saved from the tragedy of addiction and rescued from the brink of death. I certainly will do all I can to help make that possible.

Discussion

The presentation of DR. NG BAN CHEONG on "Review of Treatment and Rehabilitation Measures for Drug Users in Singapore" was followed by numerous questions asking for further details.

1. *Urine test—do you keep the patient whilst waiting for the results?*

   In Singapore, the person is never locked-up while waiting for the urine result. For example:

   (a) a person who has had treatment and rehabilitation in the centre on release is under two years compulsory supervision and aftercare. Among the conditions he has to report to the police station nearest to his home for a urine test every five days. Hence on his report to the police station, he will be informed that the previous urine sample was positive. Then and there he is sent to the drug rehabilitation centre by the Director/ Deputy of Central Narcotics Bureau (CNB).

   (b) a new suspect who has never been in the centre may also be rounded up on the street by the police. After his urine is collected, the police takes down the particulars from his identity card. He is also asked to phone his parents or a friend over 21 years to come to the police stations as a surety. The particulars of the surety are also taken down. The suspect is then released and requested to report back in a weeks time. Suppose, the result of the urine analysis is positive, the boy is immediately sent to the drug rehabilitation centre by the Director/Deputy of CNB.

2. *The structure of the centres, which Ministries are responsible for what? The size of centres?*

   The centres are under the Ministry of Home Affairs with contributing medical and nursing personnel drawn from the Ministry of Health, Probation and Aftercare Officers from the Ministry of Social Affairs. The day to day administration of the centres is by the Prisons Department which is under the Ministry of Home Affairs.

3. *How is the training of volunteers done?*

   The training syllabus for volunteer counselling and aftercare services can be obtained from Mr. Velco, the Chief Probation and Aftercare Officer in the Ministry of Social Affairs. As far as I know every applicant is screened for past criminal records and is given an aptitude test for this demand job.

4. *What are the consequences and after-effects of the cold turkey treatment?*

Since the introduction of "cold turkey" treatment in the centre since 1976, over 10,000 persons had undergone such treatment. To date none has been observed or found to have any permanent harmful injuries. No doubt, the "cold turkey" treatment is never intended to be a pleasant experience. It is not meant to be a punitive measure; but a useful learning experience. A drug addict has low threshold to frustration and to pain tolerance. Thus undergoing "cold turkey" could well be the first time in this life, that he realizes his own innate capability to overcome unpleasantness without resorting to drugs and running away from the reality of life.

5. *What happens to the ex-addicts after discharge from rehabilitation centres? Can they go back to their old jobs especially in government positions without suffering from any stigmatisation?*

An ex-addict is under two years compulsory supervision and aftercare. If he relapses into drug taking, he will be sent back to the centre where the Review Committee may extend his stay up to two years. In addition, if he also had been in the past in prison or fined by court for a drug offence, instead of coming into the centre again, he will be sentenced by the court to a three years sentence in prison. There is no unemployment in Singapore. An ex-addict can always find a job if he is not too choosy, Many large companies offer the ex-addicts back to their former employment.

6. *After-care - role of the part-time constabulary services?*

The SCNS Supervision Officers may be considered as assistants to the professional Probation and Aftercare Officers.

7. *Could you elaborate on the recidivism cases?*

Any person under the compulsory supervision and aftercare with one single positive urine is counted as a relapsed case or as a recidivist.

8. *In your experience were there any difficulties in moving your centre from the St. John island to the main island?*

The difficulties of moving the former drug rehabilitation centre from St. John Island to the main island were the same as those moving say a government department from one building to a new building some distance apart.

9. *The law related to the abscondee?*

A person who fails to return for his urine analysis result as instructed shall be guilty of an offence and shall be liable on conviction to a fine not exceeding $ 5,000 or to imprisonment for a term not exceeding two years or to both such fine and imprisonment. So far in practice, such abscondee when subsequently arrested is sent to the drug rehabilitation centre.

10. *How long would a relapsed case wait until he can be re-admitted again? How often can he be re-admitted?*

As soon as the urine result is positive, all attempts are made to contact the person, including letters and personal visits by the police to his home or place of work. As soon as he is being contacted, he is sent to the centre. At the moment, there is no fixed limit to the number of times for treatment and rehabilitation provided he has no previous imprisonment or fine by court for drug offence.

11. *Is it possible that one person would be taken to several police stations?*

A person may and some persons actually had urine collected at one police station and a few hours later were arrested as suspects and were brought to another police station for urine collection. However, in the second police station, the suspect before leaving the station., is asked whether he had a previous urine collection. If he answers in the affirmative, then the officer in charge of the second police station will contact the other police station by phone and bring the suspect back to the first police station.

12. *Elaboration on the medical team. How much is the psychiatrist involved ?*

The medical facilities in the centres comprise internists and staff nurses. There are no psychiatrists in any of the centres. The psychiatrist comes for consultation when the need arises.

13. *What type of urine analysis is used?*

The urine analysis is done by the Department of Scientific Services. Three methods are used for detection of opiates in urine:

(a) radio immunoassay
(b) thin layer chromatography
(c) gas chromatography

14. *Is there any explanation why are so many drug abusers at this time in Singapore ?*

The causes for drug abuse in Singapore is like any other countries; there are multi-factoral reasons. Perhaps, in Singapore we may have to look more closely into :

(a) the rapid urbanisation and the breaking up of extended families
(b) the emphasis on meritocracy and its effects
(c) both parents are employed and thus there is a reduction of opportunity for contact between the generations.
(d) Singapore is situated at the cross road of the world air and sea routes. The residents are exposed to good as well as to the counter-productive cultures of the world.

DR. CHARAS SUWANWELA presented his paper on "Overview of Drug Dependence Treatment Methods Available in Thailand". The following is the summary of questions and answers given.

1. *You mentioned physical and economical stress as a cause of opium addiction. What do you consider as criteria for economical stress ?*

In the hill tribal study, the prevalent rate of opium addiction was found to be significantly higher in the lower income than the higher income members in the village which had the same cultural setting and the availability of opium. When one looks further in-depth into the low income situation, one finds that they are under pressure from difficulty to sustain their living and the economic system in the place does not allow much opportunity to improve. The poverty - stress - addiction vicious cycle and the loss of hope is what we consider as economic stress.

2. *What do the villagers themselves think of addiction ? Do they know that opium is bad ?*

The villagers are indeed aware of the bad effects of opium addiction. A number of older villagers some of whom were opium addicts themselves stated that the younger generation should be discouraged from opium smoking.

Adult men and women in the village who remain single are usually addicts. It is more difficult for an addict to find a husband or a wife. In a survey of villager's attitudes, they were asked to judge whether opium smoking was good or bad and to give their reasons. Among 46 adults, some of whom were addicts, 70% stated that opium smoking was bad for various reasons, mostly economic loss. Those villagers believed that it was bad except for certain situations namely old age, sickness and for some who "were compatible" with opium. Seven considered opium smoking as good; four for its ability to treat illnesses and three for making people better and able to work.

3. *Should the Thai Government use law and law enforcement to stop opium cultivation ?*

At present the hill tribal villagers depend on opium as their main source of income to sustain their living. The crop substitution and community development, I believe, is in the right direction toward the solution of this problem. This will, however, take time. Without effective substitution, enforcement of law against opium cultivation will add serious hardship to this people. Besides, without effective help for the addicts, strict law enforcement will certainly lead to heroin addiction replacing the present opium dependence. That would be the end of this people.

I would wish that the international community does not press Thailand into these forceful measures to stop opium cultivation. We in Thailand would not do anything against their people.

4. *Would you elaborate a little about the community programmes mentioned in this report ?*

The word community is used here in the sense of the hill tribal community where we are looking at the drug addiction problem not as a problem of a person or a family but that of a community or a society. To tackle a problem in the society, one needs to understand the society, accept the limitations and impossibility within the society and does whatever one can without the unrealistic hope for an ideal situation. Our operational research programme aims at trying to solve the drug dependent problem in the setting of the whole community. Many measures may have to be indirect such as the provision of basic health care by the training of village health workers and the socio-economic development by the provision of leadership and means.

MR. DAVID TOMLINSON thereafter presented his paper on "The Changing Role of the Therapeutic Community in Treatment and Rehabilitation of Drug Dependent Persons". The questions were asked and answered.

1. *Encounter group technique seems to be substituting a religion. Is there any danger of becoming addicted to the institution ?*

All manner of institutions are in danger of creating a dependency on the part of their clients, the most obvious example is of course Prison, but also Hospital, School, College and so on with differing degrees of risk and of course differing degrees of dependency.

The T. C. in fact **encourages** initial dependency, and as long as it is recognised that this has got to be diluted as a resident progresses through his treatment plan, the risks are minimal. On the subject of encounters, they provide a useful albeit limited group tool. The danger here is that people learn to play the 'group game'; this is the time for them to move on to other experiences.

2. The community at large has to think of preventive measures, on the anticipation of drug abuse, in contradictory value systems, and the use of prescribed drugs. If we are going to make inroads into illicit drug use, we must also control the widespread use of prescribed drugs. Society's attitude to drug taking is important; perhaps if we were more preoccupied with our health and less with short cuts to alleviating stress, we would be better able to tackle addiction.

3. *Review of methods and approaches.*

A programme should be open to changing it's working methods in the light of changes on the drug scene, and in pursuit of a more effective means of rehabilitating people.

4. *How did you overcome the opposition of the society?*

I'm not sure that we have entirely succeeded, but a T.C. is almost by definition, isolated. Any way that you can keep people informed, and convinced that what you are doing is effective, should be encouraged.

5. *What are the replacements for hair cutting, etc. ?*

Facilitating residents to take more 'adult' positions about the way they deal with unacceptable behaviour and more emphasis on the group process.

6. *Psychodrama*

Psychodrama is used as an additional resource, along with role-play, video, body-work and so on, in fact we are open to use any method that will both stimulate and encourage creative problem solving.

7. *Learning experience—no humiliation ?*

We use 'learning experiences' less frequently these days, though they are invaluable in cases of relapse, aggressive behaviour and so on. The T. C. can be a very 'forgiving' institution, and the 'learning experience' can both reconcile this forgiveness in the eyes of the community while setting parameters for acceptable behaviour. However, there is a danger that any system that uses a system of sanctions, can confuse opinion with moral judgements, and almost by default have a repressive value system.

8 *Where are your clients ultimately heading ?*
Goals of your programme

I feel it is important that goals are set at a very early stage in the programme; a resident to my mind is preparing for re-entry from the day he is admitted. Therefore we consider job counselling important; training opportunities should be exploited and social objectives identified.

The following questions were asked on the presentation of the paper "Towards a more Radical Therapeutic Community" by MR. FRANK W. WILSON.

1. *Do you have a selection process ?*

Yes. Prospective residents are invited to come for a day's visit where they are introduced to the community leader who explains the philosophy and rules of the Centre. In general, this system proves to be self selecting as the would be new-comer is enabled to judge for himself if he wants to come. Obviously we make our own assessment as to whether or not we can help the applicant, but if he feels that he wants to come to us, and makes this clear at the outset, we will accept him.

2. *What is the role of religion in your programme ?*

Religion in itself may not be able to do very much. Faith in God is what we attempt to develop in our residents, if we find one of our residents becoming over-religious we discourage this as counter-productive. A gentle, gradual growth and change is the key to our spiritual therapy.

3. *Do certain types of community cater better to certain populations than others ?*

There is a place in any Therapeutic environment for experimentation with different methods, and indeed it is always possible that what we have to offer is not acceptable to every drug dependent. Often we refer those who don't wish voluntarily to come to our community to other groups. It must be a healthy situation to have more than one place to "shop" in.

4. *Could you maintain the present approach if your community were enlarged?*

The size of our Community could be enlarged by 100 percent without adversely affecting its effectiveness. However, I am of the opinion that the size is significant. Some can operate successfully with very large groups, but we find that as we are at present enables us to give a certain quality to our individual treatment of residents. To enlarge, may necessitate reducing the community to a number of smaller houses. As long as we have enough caring staff, it can be maintained.

5. *How do you deal with aggressivity or stubborness ?*

In the main these traits are dealt with in the course of daily group encounters. The residents on the whole handle difficult members very well. Another aspect is, that on the whole addicts who come into our Centre, who are fairly typical of UK addicts are not usually so aggressive that we can't control them in the normal course of events.

6. *How is your income made up ?*

Our income comes from 3 sources : Voluntary, Department of Health and Social Security and the Home Office. 40 percent of our funds come from voluntary donations whilst the rest is provided at present by the above mentioned Government Departments.

7. *Is the treatment free ?*

No charge is made to residents.

8. *How are residents referred to the centre and what are the principles of admission ?*

Residents are referred through probation officers when the Courts wish to deal with an offender who is an addict and wish voluntarily to accept a probation order rather than a prison sentence. They are

then admitted to us under a general Probation Order and whilst free to go at any time, they must seek the permission of the Probation Officer. We work very closely at this point with the Probation Officer. Other residents come to us from other referral agencies, i.e. social workers, church groups, Doctors and sometimes one-time residents or by self referral.

9. *How does the probation officer function in the UK ?*

The Probation Officer is an officer of the Court and as such is responsible to that court to see that the offender fulfils his obligations. However, there is a therapeutic input through the Probation Officer contact and he is encouraged to act liberally and not in a punitive way.

10. *Is your centre recognised by the Government ? Is there accreditation ?*

There is no Accreditation of Communities as such by the Government, but by virtue of the fact that we receive funds from the Home Office, this implies approval. The government in the UK tends towards the policy of recognizing voluntary organisations.

11. *What are the costs involved ?*

Accounts for last year show that our annual running costs for the community amount to £25,000. All capital costs and expenses related to overseas work come out of what we describe as "general funds".

12. *What is your policy on confidentiality ?*

Our policy is to encourage our residents to speak openly about the fact that they have been on drugs. Some visit schools to participate in drug prevention programmes and often tell of their experiences. However, once they leave us to take up a job and a new life outside, unless they want to still do this work, we respect their right to privacy.

13. *How many leave your centre before completing the programme ?*

About 40 percent drop out of the programme before completion. Accurate data is not yet available.

14. *Can ex-addicts giving lectures be counter-productive in your opinion?*

It is essential that only those ex-addicts with new life styles and positive attitudes to their surroundings, including their families, should be allowed to speak in public. Our ex-residents do speak in drug prevention programmes, but always with the emphasis upon the fact that drug taking is the result of wrong personal choice and not the fault of society in general. Choose carefully those whom you allow to speak in public.

15. *Do you allow groups to visit your centre ?*

We do allow and encourage visitors and on a regular basis and have dinner parties at our community when a cross section of the community at large are invited. The residents cook and serve the food.

16. *Do addicts tend to blame everybody but themselves for their condition ?*

Usually if addicts blame others for the plight they are in, it is because those who are helping them have placed their thoughts there. This attitude doesn't help the cause of recovery for the addict, simply making him feel superior and clever for being an "ex-addict" which is nothing to be proud of. Remember, a positive therapy wins result in a positive personality.

17. *What do you think of mixed groups ?*

We do not have a mixed group of males and females, although we did try this initially. We considered that the problems caused at the time were not worth the therapeutic value that mixing the group might provide. We are however open to look at this again and I'm sure our way can be open to criticism.

PART FIVE

Group Reports on Assessment Techniques

GROUP A

Chairman : Professor W. McGlothlin (USA)
Rapporteur : Dr. Vichai Poshyachinda (Thailand)

1. Group A devoted most attention to the WHO uniform drug use reporting system. It was noted that, thus far, efforts have been limited to demonstrating the feasibility of collecting such uniform data across countries with quite different patterns of drug use. It was felt that the purpose of such an ongoing effort should be further examined, both from the standpoint of WHO needs, and those of the contributing countries. While it is useful to have uniform data elements, it would appear that some additional comparability will be needed in terms of the population examined and sampling procedures employed before useful cross-cultural comparisons can be made. Even at the simplest level, this will require central coordination, and it was suggested that WHO serve in this role by establishing regular reporting channels within each participating country.

   It was further recognised that the data needs of the individual countries would far exceed those which could be uniformly reported across countries to WHO. WHO could serve the countries in this respect by providing assistance in addressing their unique requirements.

2. **Case Register**

   It was noted that case registers of drug users were being employed in a number of countries in Southeast Asia, and that their approach can provide very useful data for assessment and planning. On the other hand it was felt that this procedure raises sensitive issues of confidentiality and problems that must be considered on an individual country basis. It was not considered appropriate to attempt to suggest a uniform approach in this regard.

   It does appear that, while case registers, surveys and other drug use indicators have overlapping functions, no one approach will adequately provide demand assessment needs. By definition, case registers record those individuals who are sufficiently involved in drug use to come to the attention of physicians, teachers or various official agencies. On the other hand, surveys or other approaches for measuring drug usage in the larger population are required in order to monitor the behaviour in those who are initiating use, but have not experienced significant difficulties so that they appear in drug user registries.

3. **Substitution of drug-using behaviour**

   Very frequently, it is observed that when one particular drug is successfully controlled, there is a switch to other illicit or licit drugs. Assessing the net consequences of such change is a complex issue involving individual drug efforts, cultural values and other factors. Sometimes the

change may be quite counterproductive as in instances where the suppression of opium eating or smoking has been replaced by heroin injection. While there is no simple formula for assuring that drug control effort will have the desired effect, it is essential that countries closely monitor the **overall** impact of policy on substitute behaviour, as well as those on the target drug. By obtaining current information on this overall effect, policies can be modified at an early date in those cases where costly counterproductive effects are observed.

GROUP B

Chairman : Mr. Leslie Lee Chin Seng (Malaysia)
Rapporteur : Encik Abdullah Malim Baginda (Malaysia)

1. Definition

It is felt that a precise definition of terminology in use in the context of drug abuse is urgently needed for general application so that this can convey a common understanding of concepts, ideas and also in reference to commodities, the people we are concerned with and the various activities relating to the subject matter.

While there is apparently a need for national and/or regional definition in view of the unique situation prevailing in these areas, for the purpose of comparison, internationally acceptable definitions should be applied, especially in areas covered by international conventions.

2. Monitoring System

A monitoring system is needed in order to assist policy-makers and planners in the understanding of the problem in hand, its trends and various ramifications, and also to derive from it, a projection of future trends thereby equipping them with necessary information to guide them in the provision of various facilities to combat this problem, including law enforcement and the treatment and rehabilitation of drug abusers.

As the capability of the system is dependent on the nature and amount of information fed into it, the question of how much information is needed has been debated. For international comparative purposes, a minimum number of common items is recommended. But in order to meet national requirements, much more elaborate information may be needed.

The need for comprehensive information at the intervention level is acknowledged. However, it is felt that the number of items of information required for analytical purposes reduces as it reaches a higher level and thus finally only the very basic data are used for monitoring purposes.

It is noted that each country represented at the Workshop is formulating its own procedure for assessing the problem. This is considered desirable as the multiplicity of approaches to the problem provides a healthy growth in studying the problem from different angles. Furthermore, whatever procedure is adopted, it will be based on the situation in each country, bearing in mind the various constraints under which those responsible operate. However, it is felt desirable to apply similar or standardised techniques in assessing drug abuse.

It is difficult for any monitoring system which is based on reported incidence to be employed as a device to estimate the size of the problem population. This is because the validity of the visibility index is still debatable, as there is no real basis for such a general theory to be applied on a global basis.

It is felt, therefore, that one should refrain from making estimates based entirely on the reported incidence, it can function as an indicator of the problem in hand.

However, in order to provide as much information as possible all catchment areas ought to be covered. But due to some difficulties, some of these have to be disregarded, thus removing a proportion of the drug abuse population from being included in the system. Some device must be found to overcome this problem of discounting an unknown proportion of the population from the system. Should such a situation be allowed to continue, much more realistic statistics cannot be furnished to the policy-makers and planners.

Survey methods, however, may be employed for the purposes of making an estimate of the problem population, bearing in mind the constraint that the finding of such a survey is only valid for that particular point in time and adjustments are necessary for adoption at different times.

3. Confidentiality

The question of confidentiality was raised and it was generally felt since the monitoring system is not interested in individuals, the question of a breach of confidentiality does-not arise. But in relation to the case register where information on individuals is stored, care should be taken to prevent leakage of such information to unauthorised persons.

The exchange of information among related agencies for intervention and other activities is permissible and it does not entail a breach of anonimity in other words, a state of "restricted confidentiality" is permissible.

4. Research Areas

Cross-cultural studies relating to drug abuse problems especially on a regional basis will be very useful in view of the similarity and differences obtaining in the region.

It was also felt that while we are interested in the drug abusers, it may also be pertinent to look into those who are non-abusers in order to understand the significant qualities in the personality of the latter, the knowledge of which could be utilised in our preventive efforts.

5. International Cooperation

The value of international cooperation in this area is appreciated. The exchange of research material and findings will not only help in the understanding of the problem faced by all but also assist in refining research techniques, etc.

A clearing house for the dissemination of information, at regional or international level is very much needed. The international organisations represented at this Workshop may want to consider the setting up of such a facility.

GROUP C

Chairman: Dr. J. B. Hollinrake (Hong Kong)
Rapporteur: Dr. Erwin Widjono (Indonesia)

The following points were discussed and agreed upon by the group:

1. The desirability of the establishment of a drug abuse register and monitoring system on both national and regional level.

2. The need to conduct surveys on the reasons why narcotic drugs are **not** used by groups and/or individuals. It is suggested that such research programmes should be set up according to national and /or regional requirements and needs.

3. The need for definitions on drug abuse, misuse and dependency. The opinion was expressed that the WHO definition may be adopted as a guideline. Nevertheless, individual nations should determine their own precise definitions to suit their own requirements.

Group Reports on Treatment & Rehabilitation

GROUP A

Chairman: Dr. J. B. Hollinrake
Rapporteur: Mr. Leslie Lee Chin Seng

1. Training of Ex-drug Addicts to be Staff of Rehabilitation Centres

The need and justification for it has been established. More merits than demerits in this system are apparent. However, selection of candidates must be based on such factors as qualifications, aptitude and general suitability. Depending on the type of work, it was felt that generally the minimum school qualification should be a pass in L. C. E. or equivalent in countries with different educational systems. While it is not undesirable for the Centre concerned to conduct its own in-service training programme, it is imperative for such a programme to be evaluated and receive accreditation by an appropriate government authority. This issue related only to non-governmental Centres.

2. Establishment of Rehabilitation Centres for Hard-core Addicts by Prison Authorities

The pros and cons for establishment of such centres were discussed at length. It was agreed that such centres must make a distinction between "beginners" and criminally convicted hard core addicts. It would seem that the latter, who may not be suitable for the open system, may require the security system of environment, managed by Prison Departments. The establishment of Prison Rehabilitation Centres or Units is in keeping with the concept of modern penal administration in classifying prisoners according to needs.

3. Location and Size of Rehabilitation Centres

This issue was discussed from the point of view as to whether or not the drug dependent is a sick person or a criminal who needs to be removed from society for a certain period of time.

A concensus of opinion was reached that institutionalising him is a form of treatment and therefore he should be in an environment which can best facilitate his reintegration into the society. This being so, it was suggested that it would be highly unwise to site any rehabilitation centre in a remote place. An isolated island may create and confirm the dependant's impression that society has discarded him for good which is contrary to the principle of treatment. Furthermore, difficulty in accessibility of visits by relatives and friends may aggravate the adverse effects of institutionalisation. In island stages like Singapore and Hong Kong where remoteness is not an important issue, location of centre does not appear to present a problem.

In relation to the size of a centre, a strong feeling was expressed for a medium manageable size, for example not exceeding 200 beds. The rationale behind this is that an unduly large centre does not allow and facilitate individualised treatment, which is the underlying principle of institutional care. A controlled size, as suggested, fosters rapport between the therapists and the residents, and reduces administrative problems. In island states like Singapore and Hong Kong, modifications are necessary in view of land-scarcity.

4. Day Centres and Half-way Houses

These are indispensable components of a comprehensive rehabilitation programme and the establishment of which depend a good deal on the development of the programme in each of the countries in this region. While it is agreed that voluntary agencies should be asked to set up such an infra-structure, it is equally the responsibility of the government to make its own commitment. A distinction however, must be made between a Day Centre and a Half-way House. The former is to serve those placed on non-institutional supervision and will be particularly suitable for students and those with jobs. To be placed in a Half-way House is foreseen for those discharged from Rehabilitation Centres with the aim to help prepare them for a smooth transition from institutional life to self-responsibility in the open community.

5. Multi-modality in Treatment and Rehabilitation

Different modalities in treatment and rehabilitation are recommended taking into account differences in types of drugs abused, the personality, needs and degree of addiction of the abusers. Apart from these factors, the economic, social and cultural conditions of the dependents subject to any treatment and rehabilitation modality must also be borne in mind.

6. Exchange of Personnel (Professional)

The solution to the problem of treatment and rehabilitation programmes is constantly being involved and informed. Thus, a need was expressed for exchange of personnel engaged in the work, within one country and between countries, particularly in the region in order to update knowledge on the subject.

7. Staff for Aftercare, Re-socialization of Ex-drug Addicts

Aftercare cannot be effectively carried out without adequate professional staff. The question was raised as to what constitutes an adequate number. Quoting the experience of Malaysia, the ratio of staff to supervisees is 1 to 30 in addition to the officer proposing the 36 presentence report for the court each month. It is recommended that the realistic case-load should be between 30 - 40 cases with variation being allowed for distance, transport and mobility involved.

8. Assessment and Rehabilitation

The close relationship between these two aspects cannot be over-stressed. If the relationship is to have positive value, then each integral component within the assessment must have built-in functions for proper assessment-be it law enforcement, social work, medicine, and/or judiciary and in turn the findings of these assessments must be coordinated and interpreted for planners and policy makers in the field of rehabilitation.

GROUP B

Chairman : Dr. E. C. Senay
Rapporteur: Encik Abdullah Halim Baginda

PART I

1. The suggestion that drug dependents, having-similar basic underlying psycho-social problems to those of other deviants and therefore could well be treated or rehabilitated within the same environment, or institution was further examined by the Group. It was generally felt that at the conceptual level this may be acceptable, but in view of the peculiar situation in the different types of deviancy; be it administration legal framework, and the characteristics of these deviants themselves, it was felt not feasible to have a mixed group in this context.

   In view of our lack of experience and maturity in the area of rehabilitation of drug dependents, it is perhaps unwise at this stage of our knowledge to consider such a step although it may have some advantages. But with longer experience and proper research into this matter, some form of experimentation may be undertaken to explore this possibility.

2. On the question of mixing of the sexes in the rehabilitation centres, it was felt that the cultural norms of each country should be adhered to. Under oriental conditions, segregation of the sexes seems to be in order. Considering the expense involved in the pursuit of the mixing concept. although economical, at best, a distinctly separate area within the same institution may be set aside for female dependents.

3. Six to nine months appears to be the most preferred period of rehabilitation within the institutional setting, although some flexibility is desirable to ensure either too early a release, or the formation of institutional neurosis for those having to remain for too long. With good follow-up programmes early release is indicated so that the dependent's re-entry can be made so much the easier.

4. It is felt that there is merit in the comprehensive type of centre wherein the detoxification is conducted in the same institution where rehabilitation is carried out. However, in the less ideal situation where the rehabilitation centres are located or scattered in various places, separate units seem to be the only alternative.

5. Vocational training within the rehabilitation centres can be looked upon as providing a dual function. While it can lead to the learning of a new skill, thus enabling the individual to be self-supporting and productive, in view of the short period of stay generally recommended this goal may not be fulfilled. However, the value of its second function, as a therapeutic device should not be overlooked.

6. While there is some reservation on the question of allowing cigarette smoking in the institutional setting, some form of "restricted smoking" (i.e. at stipulated times and places) may be considered. At the same time, in line with national policy of discouraging cigarette smoking in some countries, parallel action on the part of the rehabilitation centres resulting in total denial may not be entirely out-of-line.

7. The measurement of success in drug work, should not be based entirely on drug abstinence or leading a crime-free existence, but more in terms of fulfilling the social, familial and vocational functions. The real measure of success should be gauged at some period after the formal supervision is over, i.e. when the individual is entirely free and on his own.

PART II

1. The treatment and rehabilitation programme that is being practised at the moment is still to be regarded experimental as a variety of modalities are being applied. It should be regarded as ongoing research. Proper documentation of proceedings is highly recommended. Periodical evaluation is highly desirable in terms of assessing the cost effectiveness of each modality.

   There should also be a latitude of freedom to innovate (either by employing a different modality or a mixture of modalities - in other words a multi-model project).

2. Rehabilitation should be regarded as an extended process and some form of social help must be provided during this process, e.g. halfway houses may be considered, in view of the possible difficulties the ex-patient might encounter. Strong follow-up work is essential putting the individual back with his/her family so that his/her stay could be limited to a brief one. Likewise, the concept of a centre can play a useful role in this context.

3. Society should be mobilized to assist in the after care work as a sequence of the treatment and rehabilitation effort apart from its preventive function.

4. Training is needed for all categories of workers who are in contact with drug abusers but in this area a proper selection of individuals appear to be necessary.

5. Regional meeting of operational personnel to share the experience and also the possibility of an exchange programme of operational personnel for limited period of time, approximately 3 - 6 months in the form of placement in different countries should be looked into so that a greater understanding and appreciation of the modus operandi of various approaches employed by different countries and/or agencies can be generated, as a tool for improving knowledge.

GROUP C

Chairman: Mr. Yip Peng Low (Malaysia)
Rapporteur: Mrs. Estella G. Ponce (Philippines)

PART I

The following agreements regarding the issues below are noted:

1. Cold Turkey Method

It is recognized that the "cold turkey" method can be dangerous. Hence this procedure should only be practiced under strict care and preferably medical supervision.

2. Both Sexes in One Centre

Depending on local socio-cultural conditions, separate centres should be considered for males and females for the following reasons :

(a) There might be difficulties in administration and management.

(b) Lack of competent staff to handle the mixed arrangement.

(c) Most drug abusers are emotionally immature hence illicit sex might be resorted to.

3. Size of Centre

The size of centre should depend on the availability of staff and the programme emphasis of the centre. However, it is suggested that a manageable number should not exceed more than 100.

4. Cigarette Smoking

The use of cigarettes and/or tobacco should be discouraged among the staff and residents in rehabilitation centres.

5. Establishment and Recognition of Private Centre

Private organizations should be encouraged to establish centres following the standard requirements and criteria set by the governments. Such centre should be recognized after a reasonable probation period. The centre should also be required to submit for regular evaluation a report of :

(a) programme and activities.

(b) assets and liabilities

6. Criteria of Success

Each country should set up its own criteria which should include :

(a) abstinence from drugs
(b) full re-integration to society

Follow-up of residents should start from the day he begins the after-care service and should be carried on for a period of two years.

7. Requiring Medical Practitioners to Report Cases

Since its mandatory in Malaysia to do so, a provision should be included such that confidentially will be maintained. It is noted that in other countries it is not possible to do this because such practice is contrary to the confidentiality the physician has towards his patient.

8. Punishment

Any form of punishment inflicted on the resident should be in the form of healthy activities and must contribute to the total rehabilitation of the client.

PART II

1. Detoxification and Rehabilitation to be carried out in the Rehabilitation Centre

Flexibility should be allowed depending on the condition of the addict. It is suggested that the addict should first be submitted to a medical examination and if his condition warrants detoxification then the addict should be brought to a hospital where he can have close medical supervision. Not very serious cases may go through detoxification in the rehabilitation centre.

2. Use of the Rehabilitated Drug Addicts as Lecturers

It is the consensus of the group that only rehabilitated drug addicts should be allowed to give lectures at schools, etc. This should be preceded by proper screening and in the case of minors, his/her parents consent should be obtained.

3. Training

There is a need for intensive training. This should be provided for all those working directly and indirectly with drug dependents. Such training should come in the form of:

(a) pre and on the job training for various disciplines on the local level.

(b) fellowship, observation and study grants to other countries with the support of international agencies such as Unesco, WHO, Colombo Plan Bureau, UN, US-AID.

(c) an exchange programme in terms of information and expertise should be developed.

(d) a workshop on the preparation of training materials should be held on the ASIAN level.

(e) An ASIAN journal and/or Newsletter aspects of drug abuse should be published and supported by the Colombo Plan Bureau.

4. **Separation of Chronic Drug Dependents from Criminal Cases**

A special institution should be established for hardened criminals who happen to be drug abusers.

5. **Establishment of Half-way Houses**

The group believes this is essential because of the need to prepare the individual before his full re-integration into society. Although this is an internal issue, the group recommends that this issue should be included in the overall recommendations.

SUB-COMMITTEE ON DEFINITION

Although its term of reference was to formulate a definition for a standardised term - either "drug misuse, drug abuse, drug addiction or drug dependence", the Committee did not succeed because of numerous constraints. Within the limited time available - half an hour only, it could not arrive at any definite conclusion regarding the definition, legal, social or medical, acceptable to the countries in this region. However, it examined the cross-cultural and legal differences involved and guided by the ideological similarities, the Committee felt that as broad a term as possible, perhaps not just for legal purposes, should be used. In this regard, it adopted "drug abuse", in preference to other terms, though this term was not unanimously agreed to by all the members of the Committee. It was argued that such a term requires a multi-disciplinary approach involving medical, social and legal intervention.

The idea that is conceptualised will hopefully help each national government to formulate a specific legal definition to suit its own conditions, political, social and cultural.

The **medical** component is concerned with clinical examination, observation treatment, biological, social and psychological tests.

The **social** component involves early detection and intervention by social workers to help establish the degree or otherwise of psychological dependence so as to indicate whether or not the individual can function without reliance on drugs.

The **legal and moral** question relates to whether or not the act violates public opinion, moral value and the law of the land.

It further recommends that whatever definition is decided on by the individual country - legal or otherwise - the respective national government must establish the necessary machinery and infrastructure to permit and facilitate the various components, the medical, the social welfare, the legal enforcement and the courts:

(a) to work together as a team;

(b) to have easy cross-referrals among the agencies concerned;

(c) to adhere to the code or definition adopted subject to periodical review of the respective position of each discipline or agency.

Finally, it is realised that the statement is too theoretical and requires to be concretised in precise terms for operational purposes.

PART SIX

Closing Session

SPEECH

By

Y. B. Tan Sri Datuk Haji Hamdan Sheik Tahir
Vice Chancellor, University Sains
Malaysia

Y. B. Encik Rais Yatim
Timbalan Menteri Hal Ehwal Dalam Negeri
selaku Ketua Unit Bertindak, Jawatankuasa
Kabinet mengenai Penyalahgunam Dadah, dan
juga Yang Di Pertua PEMADAM.
Y. B. Dato Mohamad bin Yelop Abdul Raof.
Y. M. Attorney Pio Abarro.
Y. M. Encik Adnan bin Haji Abdullah
Ketua Pengarah Kebajikan Am, Malaysia.
Datuk-Datuk dan seterusnya Tuan-tuan dan Puan-puan sekalian.

Pada petang yang bersejarah ini, saya merasa amat gembira kerana telah diundang ke Majlis ini dan dengan sukacitanya saya mengucapkan berbanyak terimakasih.

Setelah tuan-tuan dan puan-puan bersidang selama enam hari berturut-turut, sudah semestinyalah banyak pengetahuan baru yang diperolehi dari peserta-peserta dari negara-negara jiran. Amatlah mustahak dan penting bagi kita mengetahui keadaan yang sebenarnya berkenaan masalah yang dihadapi supaya kita semua dapat melaksanakan satu rancangan yang lebih berkesan.

Kepada Bureau Rancangan Colombo, saya mengucapkan berbanyak terimakasih kerana memberi keyakinan kepada negara Malaysia ini untuk mengendalikan Bengkel ini, terutamanya di kampus Universiti Sains Malaysia. Saya amatlah berharap keputusan Bengkel ini akan dapat digunakan oleh Bureau untuk menelorkan sesuatu rancangan baru bagi kegunaan negara-negara ahli Rancangan Colombo pada masa akan datang.

Sebagai Naib Canselor Universiti ini, saya mengucapkan selamat sejahtera kepada peserta-peserta apabila pulang ke tanah air dan saya berharap tuan tuan dan puan-puan juga akan kembali ke tempat masing-masing dengan kenagan manis dan pengetahuan yang bertambah.

Saya harap jika semasa Bengkel ini berjalan ada terdapat sebarang kekurangan dan tuan-tuan berasa tidak selesa dari segi apa-apa pun maka saya memohon maaf.

Ladies and Gentlemen,

It is my privilege both as Vice-Chancellor of Universiti Sains Malaysia as well as the Chairman of the Organising Committee for the Workshop on the Reduction of Demand for Illicit Drugs in Southeast Asia, to welcome

CLOSING SPEECH

By

H. E. Rais Yatim

Deputy Minister of Home Affairs

Government of Malaysia

Y. B. Tan Sri Datuk Hj. Hamdan Sheikh Tahir,
Naib Canselor, Universiti Sains Malaysia.

Y. B. Dato Mohamad bin Yeop Abdul Raof,
Setiausaha Kerajaan Pulau Pinang dan
Timbalan Pengerusi Majlis Universiti Sains Malaysia.

Y. M. Encik Pio Abarro,
Penasihat Dadah, Biro Rancangan Colombo.
Tan Sri-Tan Sri, Datuk-Datuk dan seterusnya Tuan-tuan dan Puan-puan.

Sukacitalah saya menyampaikan setinggi-tinggi terima kaskh kepada Jawatankuasa Pengelola Bengkel yang telah sudi menjemput saya untuk menutup Bengkel ini yang telah berlangsung selama satu minggu. Bengkel ini adalah yang ulong diadakan di Asia Tenggara, khususnya bertujuan untuk mengurangkan penggunaan dadah herbahaya dengan perhatian khas kepada penilaian rawatan serta pemulihan.

Bagi pihak Kerajaan Malaysia pula ingin saya menyampaikan terima kasih kepada pihak Rancangan Colombo yang telah berusaha hingga berjayanya Bengkel ini diadakan di Malaysia dan di Pulau Pinang bertempat di kampus yang indah ini yang amat sesuai bagi para pakar-berkenaan bertukar-tukar fikiran. Saya juga ingin menyampaikan penghargaan kepada pihak Universiti Sains Malaysia yang telah menjayakan Bengkel ini. Dengan pengalaman Universiti ini dibidang penyelidikan dan bengkel-bengkel seperti ini saya percaya USM akan terus dapat meneruskan kegiatan.

Ladies and Gentlemen,

I consider it a great honour to have been invited to address and close this "Workshop on the Reduction of Demand for Illicit Drug in South East Asia."

You are all aware that the worldwide problem of drug abuse has now assumed a notoriety of its own and created endless social dislocations. Immediate resolution is imperative. The traditional patterns of drug use which varied little in the past have changed in recent years to become problems of multiple drug use. Further traditional social controls have gradually eroded and this change has been accelerated by rapid development and urbanisation.

I am sure everyone from the South East Asian region will agree with me that drug abuse is a major issue and with the worsening of this social disease, there are now serious problems relating to health-care services, education, social behaviour, criminality, law enforcement, national security as well as the disintegration of family and community life.

In Malaysia, we are facing an increasing level of demand for illicit drugs especially amongst the young population. I am convinced that the adverse effects of drug abuse to this country is a matter of concern; for example, drug abuse can breed serious health problems. It can as a consequence of prolonged and or heavy use give rise to conditions such as malnutrition hepatitis and other forms of physiological damage. These effects can necessitate a vast expenditure of public resources if care is to be provided to the victims by society.

Drug abuse invariably results in significant increase in crime. This is particularly true in Malaysia where the levels of use are significantly high as the compulsion for the drug drives the addict to steal in order to purchase his drugs on the illicit market.

Apart from this there is also the additional welfare costs to the family of the dependent person, lost opportunities in education and training especially to the young and the incalculable losses to industrial development. It is evident that the long term social and economic costs of drug abuse often extend beyond the immediate costs.

The Government of Malaysia, fully recognising the damaging consequences, both nationally and internationally, is totally committed towards action against drug dependence. In recognition of the need for an integrated national action programme, the Cabinet Committee on Drug Abuse Control, under the Chairmanship of the Right Honourable Deputy Prime Minister, has established a National Action Unit. The Unit will serve as the executive arm of the Cabinet Committee and will be responsible for the implementation of the national drug abuse control programme.

Malaysia, by virtue of its geographical position, is faced with a serious problem of the trafficking of illicit drugs. Between the period 1970-1977 **10,886** kilograms of opium, **328** kilograms of heroin and **409** kilograms of morphine have been seized. There is also evidence to indicate that Malaysia is being used as a transit route for the trafficking of illicit drugs and as a consequence the illicit drug is easily available to the user. The Government of Malaysia is particularly concerned about the growth in recent years in the illicit traffic of drugs of abuse, especially opium and the opiates. In an attempt to reduce the availability of these drugs within the country as well as the trafficking of it to other nations the Royal Malaysian Police and other enforcement agencies have been strengthened. Further, stricter measures are being implemented, not only at all points of entry but also at exit points. The objective of these measures is to break the trafficking links, thus reducing the drug supply globally.

Statistical data available from the National Drug Dependence Monitoring System has indicated that there were as many as 32,000 persons detected for abusing narcotic drugs and of this number approximately 80%were males and below the age of 30 years. The hazardous consequences of this increase in drug abuse becomes all the more significant when one considers that at present males account for 11.2% of the population between the ages of 16-30 years in Peninsular Malaysia. Further our researchers have shown that persons who are also dependent on drugs are the biggest group of drug pushers. Research undertaken so far has also shown that the mean expenditure per addict on drugs is 10-20 ringgits per day. This means that the known addicts alone spend 326,400.00 ringgits per day or just under 120 million ringgits per year ! This figure only applies in respect of those known addicts. If we considered the estimated population of approximately 150,000 addicts, then the daily estimated expenditure on illicit drugs will be 1.53 millions ringgits or the estimated annual revenue will be nearly 560 million ringgits. These figures show why the drug trade is an extremely lucrative one.

In spite of the extremely bleak picture which exists when viewed from the overall perspective, the situation is not beyond control. My Government is fully aware of the current situation and is equally committed to a programme of multiple activities to combat and control the problem of drug abuse. Presently a multipronged attack is being undertaken by the National Action Unit to reduce the demand for illicit drugs. These activities include educational approaches, information dissemination, increasing facilities for treatment and rehabilitation and the strengthening of our research endeavours to understand the problem better.

This Workshop has been mainly concerned on two aspects of the problem-the assessment of demand and that of treatment and rehabilitation.

An important component of demand reduction activity is the availability of up-to-date and accurate information on the types, patterns, characteristics and consequences of illicit drugs which are being abused in different areas. This activity known in scientific language as "assessment" is a major activity in Malaysia.

A national research programme on drug abuse is being carried out here at Universiti Sains Malaysia, on behalf of the Government. The research activities include epidemiological studies aimed at establishing an ecological profile of drug abuse and related problems; the evaluation of current and new therapeutic modalities used in the management of drug dependent persons; psycho-chemical, pharmacological and numerous other studies. With all these studies, the research unit will be in a position to serve as the **National Data Bank** for the policy-makers.

I am convinced that research has an important role, for without information of the existing nature and trends of drug abuse, the setting of prevention goals may prove to be a futile activity. You will agree that without reliable information about the characteristics of the phenomenon effective means to reach the objectives cannot be devised.

Further, research and the evaluation of the present methods of social interventions in drug abuse will also tell both the researcher and policy form ulator much about the adequacy of the present policies and programmes and perhaps suggest particular courses of action. I have been connected closely with our national research programme at Universiti Sains Malaysia and the basic philosophy adopted in developing the different activities has proved to be extremely successful.

Apart from assessment problems, you have also been deliberating on treatment and rehabilitation. The elemination of drug abuse in those who have undergone treatment and/or rehabilitation is not only a humanitarian effort but also an essential activity in demand reduction.

The history of the treatment and rehabilitation of a drug dependent person shows that these processes have, on the whole, been largely unsuccessful. It is not possible to devise one type of approach or technique in treatment and rehabilitation that can be considered ideal or serve as a model. In developing such programmes, it is necessary to consider the cultural factors as well as a wide range of other factors such as age, educational level, psychological maturity, social milieu and work experience. In this context vocational rehabilitation plays an important part in the process of the reintegration of a drug dependent person into society.

Since different individuals require a different approach in re-establishing themselves as useful citizens, a multi-modality programme of rehabilitation is being implemented in Malaysia. We have the 'therapeutic activity' type programme being undertaken by the Ministry of Welfare Services. In the very near future we will be setting up two Centres for drug rehabilitation under the Prisons Department. This programme will lay strong emphasis on discipline, personal behaviour, job attitude, vocational training and psycho-social therapy. A third approach is the "therapeutic community" which is the modality used by the Help Centre at Batu Gajah.

You may wonder why Malaysia has decided to commence a programme of rehabilitation under the enforcement authorities i.e. the Prisons Department. We are now convinced that the problem of rehabilitation of drug addict is different from other socially disabling diseases.

REMARKS

By

Attorney Pio A. Abarro
Drug Adviser, Colombo Plan Bureau

Honourable Deputy Minister of Home Affairs, Mr. Rais Yatim, Honourable Datuk Hadji Hamdan Sheik Tahir, Vice-Chancellor, University Sains Malaysia, Director-General Adnan bin Haji Abdullah, Fellow Participants and Friends :

It gives me great pleasure to have the opportunity of addressing you once again during this closing ceremony. I am thankful to the Honourable Deputy Minister for his presence with us today in bringing to a close this seven-day Workshop on "Reduction of Demand for Illicit Drugs in South-East Asia". Everyone of us is aware that despite his youthful appearance his concern for prevention and control of drug abuse, particularly among the youth in Malaysia, has been long recognised and admired. His concern towards this problem was well expressed in his address to you today. This is further strengthened by his appointment as head of the Action Committee on Drug Abuse of the Cabinet Committee on Narcotics Control. I am also thankful to my friend Hon.Datuk Hadji Hamdan Sheik Tahir, Vice-Chancellor, University Sains Malaysia, for his untiring contribution towards the success of this exercise. As we close this Workshop today after seven days of hard work, I wish to thank the consultants and participants and through them the member Governments of the Colombo Plan for their cooperation by way of allowing your participation in this exercise.

During the week we discussed in depth two important aspects of the drug abuse problem, namely, reduction of demand for illicit drugs and treatment and rehabilitation of drug dependent persons. We have shared our experiences with other countries, experts and participants and we will return to our home countries richer in knowledge and in shared experiences. I am hopeful that the Workshop will prove to be of immense benefit not only to this part of the region but outside as well.

Finally, I must thank those silent workers, the staff of the Secretariat and others who gave their best to make this Workshop a success that it is. May I wish you all more success in your future undertakings - Terima Kasi.

PART SEVEN

List of Participants

TECHNICAL COMMITTEE

Attorney Pio A. Abarro (Colombo Plan Bureau) } Co-chairmen
Professor George M. Ling (United Nations) }

Adnan bin Haji Abdullah (Malaysia)

Dr. P. H. Hughes (World Health Organization)

Dr. M. Kilibarda (United Nations Division of Narcotic Drugs)

Professor W. McGlothlin (Consultant)

Dr. V. Navaratnam (Malaysia)

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Y. B. Encik Rais Yatim
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Mr. Adnan bin Haji Abdullah	- Chairman, Treatment and Rehabilitation
Mrs. Eva Tongue	- Rapporteur - General
Mr. Khalid bin Isa	- Secretary

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